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GENERAL PROGRAM INFORMATION

Provider Participation in the California Medi-Cal Dental Program

To receive payment for dental services rendered to Medi-Cal beneficiaries, prospective providers must apply and be approved by Denti-Cal to participate in the California Medi-Cal Dental Program, the details of which may be found below in the section entitled Requirements for Participation in the California Medi-Cal Dental Program. When a provider is enrolled in the Denti-Cal program, Denti-Cal sends the provider a letter confirming the provider's enrollment effective date. Denti-Cal will not pay for services until the provider is actively enrolled in the Denti-Cal Program.

The Denti-Cal Provider Enrollment Department assigns each dental provider a unique eight-digit provider identification number, used to identify the provider throughout the claims processing system. This unique identifier is comprised of an alpha character, the provider's dental license number and the provider's service office number. The Provider Enrollment Department also:

- Accepts and verifies all applications for enrollment in the California Medi-Cal Dental Program;
- Makes changes to Denti-Cal provider name and address records;
- Updates the enrollment status of providers for Denti-Cal records.

Denti-Cal also maintains a separate database, the Manual Purchasers List, providing names and addresses of agencies interested in receiving bulletins and Provider Manual updates. This database also lists a provider's request to have more than one copy of bulletins, or Provider Manuals and quarterly updates sent to the office or to a separate location. In order to receive all necessary information regarding the Denti-Cal program, it is imperative that this data be correct so please contact Denti-Cal as soon as there is any type of address change.

Requirements for Participation in the California Medi-Cal Dental Program

1. Each Medi-Cal dental provider must keep and maintain, for a minimum period of three years from the date of service, all records which are necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary (Title 22, California Code of Regulations, Section 51476).
2. No provider may refuse, or fail to make available during regular business hours, all pertinent records concerning the provision of health care services to a Medi-Cal beneficiary, to any authorized representative of the state or federal government acting in the scope and course of his or her employment.
3. Providers must comply with Title VI of the Civil Rights Act of 1964 (PL 88-352), the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and all requirements imposed by the DHHS (45 CFR Part 80), which states that "no person in the United States shall, on the ground of race, color, religion, sex, age, disability, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program of activity for which the applicant receives state financial assistance from the Department." In addition, providers must comply with California Department of Corporations laws and regulations, which forbid discrimination based on marital status or sexual orientation (Rule 1300.67.10, California Code of Regulations).
4. Providers may not submit a claim to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal Program's scope of benefits, in addition to a claim submitted to the Medi-Cal Program for that service, except to collect payments due where the benefits available under the Medi-Cal Program duplicate those provided under other contractual or legal entitlements of the person or persons receiving them (W&I Code, Section 14019.3).

5. Providers must certify that the services listed on the treatment form have been personally provided to the beneficiary by the provider or, under his or her direction, by another person(s) eligible under the Medi-Cal program to provide such services, and such person(s) must be designated on the treatment form. The provider must also certify that the services were, to the best of the provider's knowledge, necessary to the health of the beneficiary. The provider must further acknowledge that he or she understands payment for services rendered will be made from federal and/or state funds and that any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws.
6. Out-of-state providers who wish to be reimbursed by Denti-Cal for services provided to California Medi-Cal beneficiaries are subject to specific regulations under Sections 51006 and 51056, Title 22, California Code of Regulations (CCR). These rules are as follows:

Title 22, California Code of Regulations (CCR), Section 51006.

Out-of-State Coverage

(a) Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:

(1) When an emergency arises from accident, injury or illness; or

(2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or

(3) Where the health of the individual would be endangered if he undertook travel to return to California; or

(4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the state; or

(5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the state.

(6) Prior authorization is required for all out-of-state services, except:

(A) Emergency services as defined in Section 51056.

(B) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state.

(b) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

Title 22, California Code of Regulations (CCR), Section 51056.

Emergency Services

(a) Emergency services means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

(b) Emergency services are exempt from prior authorization, but must be justified according to the following criteria:

(1) Any service classified as an emergency, which would have been subject to prior authorization had it not been so classified, must be supported by a physician's, podiatrist's or dentist's statement which describes the nature of the emergency, including relevant clinical information about the patient's condition, and states why the emergency services rendered were considered to be immediately necessary. A mere statement that an emergency

existed is not sufficient. It must be comprehensive enough to support a finding that an emergency existed. Such statement shall be signed by a physician, podiatrist or dentist who had direct knowledge of the emergency described in this statement.

(2) The Department may impose post service prepayment audit as set forth in Section 51159(b), to review the medical necessity of emergency services provided to beneficiaries. The Department may require providers to follow the procedures for obtaining authorization on a retroactive basis as the process for imposing post-service prepayment audits. Requests for retroactive authorization of emergency services must adequately document the medical necessity of the services and must justify why the services needed to be rendered on an emergency basis.

(c) Program limitations set forth in Sections 51304 and 51310 are not altered by this section.

The above requirements for participation in the California Medi-Cal Dental Program are contained on the back of the Denti-Cal treatment forms. Before you sign a Denti-Cal treatment form, it is important that you read and understand the information on the back of the form.

When you sign the form and submit it to Denti-Cal, you are certifying your agreement to comply with all of these requirements.

If you have any questions about these requirements, please contact Denti-Cal toll-free at (800) 423-0507. To obtain an application for enrollment, report name and address changes, or to obtain information concerning your current enrollment status, contact:

Denti-Cal
California Medi-Cal Dental Program
Provider Services
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

Program Enrollment

New Versions of the Provider Application and Disclosure Forms

Effective April 17, 2006, the Denti-Cal Program will utilize the same applications used by providers participating in the Medi-Cal Program. All provider application and disclosure forms have been changed to comply with the disclosure requirements of California Code of Regulations, Title 22, Sections 51000.30, 51000.31, 51000.35, and 51000.40.

Welfare and Institutions Code (W&I Code) Section 14043.15(a) grants the California Department of Health Services (Department) the authority to adopt regulations for the certification of each applicant and each provider in the Medi-Cal Program.

W&I Code Section 14043.15(b)(1) requires that applicants who are natural persons licensed or certificated under the Business and Professions Code or the Osteopathic or Chiropractic Initiative Acts to provide health care services, or who are professional corporations under subdivision (b) of Section 13401 of the Corporations Code, must enroll in the Medi-Cal Program as either individual providers or as rendering providers in a provider group. This is true even if the person or the professional corporation meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

W&I Code Section 14043.26(a)(1) requires that an applicant not currently enrolled in the Medi-Cal Program, or a provider applying for continuing enrollment, upon written notification from the Department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continued enrollment, or enrollment at a new location or a change in location.

Based upon the authority granted to the Director of the Department in W&I Code Section 14043.75(b), the Director hereby designates the following revised applications and disclosure statements that shall be completed by an applicant or provider when required by the California Code of Regulations (CCR), Title

22, Sections 51000.30, 51000.31, 51000.32, 51000.35, and/or 51000.40. This designation is a regulation implementing W&I Code Section 14043.15 and 14043.26 and has the full force and effect of law. This designation is effective for all application and disclosure packages received on or after April 17, 2006. Those applications mailed prior to April 17, 2006 will continue to be processed until June 15, 2006, under the rules and regulations in effect at the time the application and disclosure packages were received.

The applicant or provider, when required pursuant to CCR, Title 22, Sections 51000.30, 51000.31, 51000.32, 51000.35, and/or 51000.40, shall complete and submit, as applicable, the following applications and forms:

- Medi-Cal Provider Group Application - DHS 6203 (Rev. 1/06)
- Medi-Cal Provider Application - DHS 6204 (Rev. 1/06)
- Medi-Cal Disclosure Statement - DHS 6207 (Rev. 1/06)
- Medi-Cal Provider Agreement - DHS 6208 (Rev. 1/06)
- Medi-Cal Supplemental Changes - DHS 6209 (Rev. 1/06)
- Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers - DHS 6216 (Rev. 1/06)
- Successor Liability with Joint and Several Liability Agreement - DHS 6217 (Rev. 1/06)

Providers have two options to receive the new enrollment application forms:

1) Download the applications from the California Medi-Cal Web site at http://www.medi-cal.ca.gov. Go to Provider Enrollment; Application Forms. Applications shall only be printed on one side, not duplexed (i.e., double-sided).
2) Contact the Denti-Cal Telephone Service Center at (800) 423-0507 and request that an application package be mailed.

Changes to
Rendering Provider Enrollment Process

Due to a change in *California Code of Regulations* (CCR), Title 22, §51000.31(b), rendering providers now need to apply to the Medi-Cal Dental Program (Denti-Cal) only once.

To initially enroll as a rendering provider, the applicant needs to submit a complete application package. All required forms can be obtained by contacting the Telephone Service Center at (800) 423-0507.

Rendering providers in good standing may join existing provider groups or practice at other locations without having to submit a new application package each time.

In order for Denti-Cal to maintain an accurate Beneficiary Referral Listing, we request that you continue to notify Denti-Cal when associating or disassociating a specialist to your practice.

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Figure 2-1

Medi-Cal Provider Group Application (DHS 6203, Rev. 1/06)

A Medi-Cal Provider Group Application form is required to report any of the following enrollment actions:

- A dentist with two or more rendering dentists requesting to apply as a Medi-Cal Dental Program provider.
- A group dentist changing or requesting to add an additional business address.
- A group dentist changing a Taxpayer ID number.
- A group dentist changing ownership in the practice.

Further instructions are included on the DHS 6203.

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL PROVIDER GROUP APPLICATION

Important:
- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:

Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 323-1945

For Denti-Cal return completed forms to:

Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

FOR STATE USE ONLY

Enrollment action requested (check all that apply)

Date / /

☐ New provider

For any of the following actions, include current Medi-Cal group provider number: _____

☐ Change of business address
☐ Additional business address
☐ New Taxpayer ID number
☐ *Change of ownership (per Title 22, CCR, Section 51000.6)
☐ *Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
☐ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
☐ *Sale or transfer of assets (50 percent or more) (per Title 22, CCR, Section 51000.30)
☐ Deletion of one or more rendering providers resulting in one remaining rendering provider.

☐ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)
☐ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

***A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Type of entity (check one)

☐ Sole proprietor ☐ Corporation: ☐ Limited Liability Company (LLC): ☐ Nonprofit Corporation
☐ Partnership Corporate number: _____ LLC number: _____ Type of nonprofit: _____
☐ Government entity State incorporated: _____ State registered/filed: _____ ☐ Other: _____

1. Legal provider group name (as listed with the IRS)

2. Is this a fictitious business name? ☐ Yes ☐ No
If yes, list the Fictitious Business Name Statement/Permit number | Effective date / /
(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

3. Provider group telephone number ( )

4. Provider group business address (number, street) | City | County | State | Nine-digit ZIP code

a. ☐ This address is a licensed hospital/health facility. ☐ Yes ☐ No

Check the option that applies:

b. ☐ All services are provided at this location.

c. ☐ I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all business addresses where the provider renders services.

5. Pay-to address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

7. Taxpayer Identification Number (TIN) or social security number (Attach a legible copy of the IRS form)

8. Medicare billing number (Attach a legible copy)

9. Seller's Permit number (attach a legible copy)

10. Type of provider group

11. If physician(s) or dentist(s), list specialty(ies)

12. **Hospital Privileges** (answer if a physician provider group)

a. Do all of your physicians have current hospital privileges? ☐ Yes ☐ No

If no, please explain: _____

If yes, please enter the following (attach additional sheets if needed):

Name of physician | Name of Hospital | Telephone number ( )
Address (number, street) | City | State | Nine-digit ZIP code

Name of physician | Name of Hospital | Telephone number ( )
Address (number, street) | City | State | Nine-digit ZIP code

Figure 2-2

Medi-Cal Provider Application (DHS 6204, Rev. 1/06)

A Medi-Cal Provider Application form is required to report any of the following enrollment actions:

- A sole-proprietor dentist changing or adding an additional business address.
- A sole-proprietor dentist changing his/her Taxpayer ID number.
- A sole-proprietor dentist changing ownership in the practice and/or reporting a cumulative change of 50% or more ownership or controlling interest.

Further instructions are included on the DHS 6204.

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL PROVIDER APPLICATION

FOR STATE USE ONLY

Important:
- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:

  Department of Health Services
  Provider Enrollment Branch
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

  For Denti-Cal return completed forms to:

  Medi-Cal Dental Program
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

Enrollment action requested (check all that apply)

Date / /

❒ New provider
For any of the following actions, include current Medi-Cal number: _____

❒ Change of business address
❒ Additional business address
❒ New Taxpayer ID number
❒ *Change of ownership (per Title 22, CCR, Section 51000.6)
❒ *Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
❒ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
❒ *Sale of assets 50 percent or more, per Title 22, CCR, Section 51000.30)
❒ Continued Enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)

❒ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

***A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000 32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Type of entity (check one)

❒ Sole proprietor
❒ Corporation:
Corporate number: _____
State incorporated: _____
❒ Partnership (attach legible copy of agreement)
❒ Limited liability company (LLC):
LLC number: _____
State registered/filed: _____
❒ Government entity
❒ Nonprofit Corporation
Type of nonprofit: _____
❒ Other: _____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement/Permit number

Effective date / /

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street) | City | County | State | Nine-digit ZIP code

a. ❒ This address is a licensed hospital/health facility ❒ Yes ❒ No

Check the option that applies

b. ❒ All services are provided at this location.

c. ❒ I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all business addresses where the provider renders services.

5. Pay-to address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

7. License number (attach legible copy) | License effective date / / | License expiration date / / | 8. Provider type | 9. Medicare billing number (attach a legible copy)

10. Taxpayer Identification Number (TIN) issued by the IRS (attach a legible copy of the IRS form) – | 11. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 5.) – –

12. (Nurse Practitioner only) Duration of training program and school | 13. (Nurse Practitioner only) Clinical and didactic training or equivalent experience completed

14. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy) | 15. State Laboratory License/Registration number (attach a legible copy) | 16. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

Figure 2-3

Medi-Cal Disclosure Statement (DHS 6207, Rev. 1/06)

A Medi-Cal Disclosure Statement is required when either the Medi-Cal Provider Application (DHS 6204) or Medi-Cal Provider Group Application (DHS 6203) are submitted.

Further instructions are included on the DHS 6207.

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL DISCLOSURE STATEMENT

Do not leave any questions, boxes, lines, etc., blank. Check or enter N/A if not applicable to you.

I. APPLICANT/PROVIDER INFORMATION

A. Legal name of applicant/provider as reported to the IRS

B. Legal name of applicant/provider as it appears on professional license *(if applicable)* ☐ N/A

C. Existing Medi-Cal Provider Number(s) *(if applicable)* ☐ N/A

D. If applying as a rendering provider to a provider group, check here ☐ and proceed to Part I below.

E. Fictitious business name *(if applicable)* ☐ N/A

F. "Doing Business As" name *(if applicable)* ☐ N/A

G. Address where services are rendered or provided (number, street) (City) (State) Nine-digit (ZIP code)

1. Does applicant/provider lease this location? ☐ Yes ☐ No
2. If yes, provide the following information regarding Lessor:
   a. Lessor name
   b. Lessor address (number, street) (City) (State) Nine-digit (ZIP code)
   c. Lessor telephone number d. Term of lease e. Amount of lease
3. If no, does applicant/provider own this location? ☐ Yes ☐ No
4. If applicant/provider does not lease or own this location, explain below:

H. Type of Entity *(must check one)*:

☐ General Partnership *(Enclose Partnership Agreement)*
☐ Limited Partnership *(Enclose Partnership Agreement)*
☐ Limited Liability Partnership *(Enclose Partnership Agreement)*
☐ Sole Proprietor (Unincorporated)
☐ Limited Liability Company: State of formation: _____
☐ Governmental
☐ Corporation: Corporate number: _____ State incorporated: _____
☐ Nonprofit:
Check one:
☐ Corporation
☐ Unincorporated Association
Check one:
☐ Charitable
☐ Religious
☐ Other *(specify)*: _____

I. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐ N/A

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
$		/ /	/ /
$		/ /	/ /

Do not leave any questions, boxes, lines, etc., blank.

Figure 2-4

Medi-Cal Provider Agreement (DHS 6208, Rev. 1/06)

A Medi-Cal Provider Agreement is required when either the Medi-Cal Provider Application (DHS 6204) or Medi-Cal Provider Group Application (DHS 6203) are submitted.

Further instructions are included on the DHS 6208.

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL PROVIDER AGREEMENT

(To Accompany Applications for Enrollment or Continued Enrollment)*

FOR STATE USE ONLY

Do not use* staples *on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date / /

Legal name of applicant or provider (hereinafter jointly referred to as "Provider")

Medi-Cal provider number (new applicants should leave blank)	Medicare billing number	Business telephone number ( )	
Business address (number, street)	City	State	Nine-digit ZIP code
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

Taxpayer identification number**

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH SERVICES (HEREINAFTER "DHS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHS in the Medi-Cal program. DHS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 25(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program. During any period in which the provider is on provisional provider status or preferred provisional provider status, DHS may terminate this agreement for any of the grounds stated in Welfare and Institutions Code Section 14043.27(c).

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

3. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.

* Every applicant and provider must execute this Provider Agreement, except physicians, who must execute the "Medi-Cal Physician Application/Agreement," DHS 6210.

** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

Figure 2-5

Medi-Cal Supplemental Changes (DHS 6209, Rev. 1/06)

A Medi-Cal Supplemental Changes application form is required to report any of the following actions:

- To add a:
  - Business activity
  - DBA name
  - License, permit, certification, etc.
  - Specialty code
- To delete a:
  - Specialty code
- To change:
  - A pay-to or mailing address and/or phone number
  - A person with ownership or control interest less than 50%
  - DBA name
  - Other information, e.g., legal name change (marriage, etc.)
- Miscellaneous:
  - Issuance of new PIN number

Further instructions are included on the DHS 6209.

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL SUPPLEMENTAL CHANGES

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:

  Department of Health Services
  Provider Enrollment Branch
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

  For Denti-Cal return completed forms to:

  Medi-Cal Dental Program
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

FOR STATE USE ONLY

Legal provider name (as listed with the IRS)	Medi-Cal provider number	Date
		/ /

PROVIDER TYPE (check one)

- ☐ Dentist
- ☐ DME
- ☐ Laboratory
- ☐ Orthotic and prosthetic
- ☐ Pharmacy
- ☐ Physician
- ☐ Provider group
- ☐ Registered Dental Hygienist Alternative Practice
- ☐ Transportation
- ☐ Other provider type (please describe) _____

ACTION REQUESTED (check all that apply)

Add:

- ☐ Business activity
- ☐ Clinical Laboratory Improvement Amendment (CLIA)
- ☐ Doing-Business-As (DBA) name
- ☐ Licenses, permits, certificates, etc.
- ☐ Medical transportation vehicle, driver or pilot
- ☐ Seller's Permit
- ☐ Medicare billing number
- ☐ Specialty code

Delete:

- ☐ Clinical Laboratory Improvement Amendment (CLIA)
- ☐ Medical transportation vehicle, driver, or pilot
- ☐ Specialty code

Change:

- ☐ Address and/or phone (pay-to or mailing only)
  List provider number the change is associated with:
  _____
- ☐ Medical transportation vehicle, driver, pilot or geographic area served
- ☐ Persons with ownership or control interest less than 50 percent
- ☐ Pharmacist-in-charge
- ☐ Managing employee
- ☐ Hours of operation
- ☐ Business activities
- ☐ Doing-Business- As (DBA) name
- ☐ Other information previously submitted in an application package

Miscellaneous:

- ☐ Deactivate provider number
  - ☐ PIN (Provider Identification Number)
  - ☐ Issuance (new PIN)
- ☐ Confirmation (existing PIN)

Complete only the boxes specific to the action requested. Complete boxes 34–39. Complete box 40, if applicable.

General Information

1. Business name, if different		2. Business telephone number
		( )
Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date / /
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit, if applicable.)	

3. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
4. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

5.a. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)	5.b. State Laboratory License/Registration number (attach a legible copy)	6. Medicare billing number (attach a legible copy)
7. Seller's Permit number (attach a legible copy)	8. Any local business license, permit or certificate numbers (attach a legible copy)	9. Specialty code(s), if applicable Add: _____ Delete: _____

Figure 2-6

Medi-Cal Rendering Provider Application/Disclosure Statement/ Agreement for Physician/Allied Dental Providers (DHS 6216, Rev. 1/06)

A Medi-Cal Rendering Provider Application is required:

- When adding a new (unenrolled) Rendering Provider new to the Medi-Cal Dental Program.

Further instructions are included on the DHS 6216.

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED/DENTAL PROVIDERS

FOR STATE USE ONLY

Important:
- Read all instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to: For Denti-Cal return completed forms to:

Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 323-1945

Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

☐ Preferred provider status requested pursuant to Welfare and Institutions Code Section 14043.26(c). All qualifying documentation and cover letter attached.

Do not use staples on this form or on any attachments.
Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check[✓] all that apply)
☐ New rendering physician/allied/dental provider

Date / /

Provider Type (check one)
☐ Audiologist
☐ Certified Nurse Midwife
☐ Certified Registered Nurse Anesthetist
☐ Chiropractor
☐ Dentist
☐ Optometrist
☐ Orthotist
☐ Physician
☐ Podiatrist
☐ Prosthetist
☐ Psychologist
☐ Registered Dental Hygienist Alternative Practice
☐ Other: _____

1. Legal name of applicant (last name) (first name) (middle name) | 2. Date of birth / / | 3. Gender

4. Residence address (number, street) | City | State | Nine-digit ZIP code

5. Social security number | 6. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

7. Professional license/certified certificate/permit number (attach legible copy) | License effective date / / | License expiration date / / | List specialty(ies)—Physicians and dentists only | Board-certified Yes ☐ No ☐ | Board-eligible Yes ☐ No ☐

8. Business address (office/hospital) (number, street) | City | County | State | Nine-digit ZIP code

9. Business telephone number ( ) | 10. Contact person's name | 11. Contact person's telephone number ( ) | 12. Contact person's email address

13. Medi-Cal number of Group being Joined

14. Proof of Professional Liability Insurance-Applicant must attach a copy of their certificate of (malpractice) insurance to this application.

Name of Insurance company

Insurance policy number | Date policy issued (mm/dd/yyyy) / / | Expiration Date of policy (mm/dd/yyyy) / /

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number ( ) | Fax number ( ) | E-mail address

DISCLOSURE INFORMATION

Respond to the following questions:

1. ***Within ten years of the date of this statement***, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): / /
2. ***Within ten years of the date of this statement,*** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of final judgment (mm/dd/yyyy): / /
3. ***Within ten years of the date of this statement,*** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): / /

Figure 2-7

Successor Liability with Joint and Several Liability Agreement (DHS 6217, Rev. 1/06)

A Successor Liability form is required to transfer liability in the result of a sale or practice.

Along with this form, providers are reminded to complete and submit either the Medi-Cal Provider Group Application (DHS 6203) or Medi-Cal Provider Application (DHS 6204) as well as the Medi-Cal Disclosure Statement (DHS 6207) and Medi-Cal Provider Agreement (DHS 6208).

Further instructions are included on the DHS 6217.

State of California–Health and Human Services Agency — Department of Health Services

SUCCESSOR LIABILITY WITH JOINT AND SEVERAL LIABILITY AGREEMENT

This section is to be signed and dated by provider transferor and transferee applicant:

_____ and _____ acknowledge that
(legal name of provider transferor on file with IRS) (legal name of transferee applicant on file with IRS)

the Medi-Cal Provider Agreement between the provider transferor and the California Department of Health Services for the business operations at this location is being assigned to the transferee applicant effective _____. The provider transferor and transferee applicant acknowledge
(effective date of transfer)

and agree that he/she/they/it will be jointly and severally liable for all debts arising from the Medi-Cal Provider Agreement applicable to the location for which the transferor's provider number was issued, until the Medi-Cal provider number transferred pursuant to this agreement is deactivated.*

FOR PROVIDER TRANSFEROR

Signed this _____ day of _____, _____
(day of month) (month) (year)

in _____, California.
(name of county where signed)

_____ _____
(signature of provider transferor) (date)

_____ _____
(current Medi-Cal provider number of provider transferor) ("Fictitious Business" name of provider transferor, if applicable)

FOR TRANSFEREE APPLICANT

Signed this _____ day of _____, _____
(day of month) (month) (year)

in _____, California.
(name of county where signed)

_____ _____
(signature of transferee applicant) (date)

_____ _____
(current Medi-Cal provider number of transferee applicant, if applicable) ("Fictitious Business" name of transferee applicant, if applicable)

I _____, declare under penalty of perjury under the laws of
(name of transferee applicant)

the State of California that I meet all of the requirements to be a Medi-Cal provider.

_____
(date of signature)

Executed at _____, _____, on _____.
(city) (state) (date)

*Deactivation of the Medi-Cal provider number will be caused by transferee applicant's application for a new Medi-Cal provider number being approved, or being denied.

Notary Public

Notarization is required. The Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

This letter should be postmarked no later than five (5) days after the occurrence of the circumstance listed in California Code of Regulations (CCR), Title 22, Section 51000.30(b). The transferee applicant must submit a complete application package to be received by the Department within 35 days of the occurrence of a circumstance listed in (b)(1), (b)(2), (b)(6), or (b)(7). This is required per CCR, Title 22, Section 51000.30(b).

DHS 6217 (1/06)

Provisional Provider Status

The Department of Health Services (Department) implemented Senate Bill (SB) 857, effective January 1, 2004, establishing a provisional provider status to allow for more efficient identification of problematic and fraudulent providers.

The Welfare and Institutions Code has been amended to include the following:

Section 14043.26 - New providers will be enrolled as "provisional providers." These providers shall be subject to the terms of provisional provider status for a period of 12 months from the date of enrollment. After successful completion of the 12-month provisional period, the provider's status will be changed to reflect regular, active status.

All applications must be processed within 180 days and, upon approval, are granted provisional provider status for 12 months. If the provider is not notified after 180 days, provisional provider status will be automatically invoked.

Section 14043.28 - Providers who are subsequently denied enrollment will not be eligible to reapply for a period of three (3) years.

Section 14123.25 - Providers will be notified of improper billing practices via deficiency notices. Subsequent notices to the same providers may result in civil penalties being imposed by the Department.

Section 14172.5 - The Department shall pursue liquidation of overpayment 60 days after issuance of the first statement of accountability or demand for repayment, regardless of the status of the provider's appeal.

Verify Your Tax Identification Number

The California Medi-Cal Dental Program (Denti-Cal) reports annually to the Internal Revenue Service (IRS) the amount paid to each enrolled billing provider. The Business Name and Tax Identification Number (TIN) must match **exactly** with the name and TIN on file with the IRS. If the Business Name and TIN **do not** match, the IRS requires Denti-Cal to withhold 31% of future payments.

Tax Identification Number

TINs may either be a Social Security Number (SSN) or an employer identification number (EIN). Denti-Cal uses the TIN to report earnings to the IRS, which are printed on the front of the check and on the Explanation of Benefits (EOB) you receive from Denti-Cal. **Please verify that the Business Name and TIN on the next check/EOB you receive from Denti-Cal are correct.** If the Business Name and TIN appearing on your Denti-Cal check/EOB are correct, you do not need to notify Denti-Cal.

Updating Your Tax Identification Number

If the Business Name and/or TIN are not correct, a Medi-Cal Dental Provider Information Change/Deletion Request (DC-012) form is required to make necessary changes. Please attach a valid, legible copy of an official document **from** the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109C).

If your business type has changed (for example: sole proprietorship, corporation or partnership) you are required to complete a new Medi-Cal Dental Provider Number Request (DC-005), Medi-Cal Disclosure Statement (DHS 6207), and Medi-Cal Provider Agreement (DHS 6208).

If you are incorporated, attach a valid, legible copy of the Articles of Incorporation showing the name of the corporation. If you are doing business under a fictitious name, attach a valid, legible copy of the fictitious name permit issued by the Dental Board of California.

To obtain a current application package, please contact Denti-Cal toll-free at (800) 423-0507. Failure to submit the appropriate form(s) and supporting documents will delay the processing of your application and it will be returned as incomplete.

TAX IDENTIFICATION CHANGE INFORMATION

Provider ID Number _____ Service Office Number _____

Doing Business As Name _____

Tax Identification Number __ __ __ - __ __ - __ __ __ __ ***or*** __ __ - __ __ __ __ __ __ __
(SSN) (EIN)

Billing Provider Name _____
(Please Print)

Billing Provider's Signature _____ Date _____

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12 Month No Claim Activity

In order to remain actively enrolled in the Medi-Cal Dental Program, providers must comply with all enrollment requirements.

Medi-Cal Dental Program providers will automatically be inactivated from the Medi-Cal Dental Program if any of the following occurs:

- Dental license is expired, revoked, inactivated, denied renewal, or suspended by the Dental Board of California;
- Mail is returned by the post office marked "Undeliverable" due to incorrect address;
- Twelve months with no claim activity in the Medi-Cal Dental Program.

Upon inactivation, providers will be required to re-apply in the Medi-Cal Dental Program.

To ensure you receive the most current enrollment application and information, please request an application by calling Provider Services at (800) 423-0507.

As a participating Denti-Cal provider, it is important to keep Denti-Cal records up to date by promptly reporting any changes in practice, such as name and address changes, the addition of associates or the sale of your practice. You must notify Denti-Cal in writing to change or correct your provider name/address information. Denti-Cal cannot make any changes to your provider information record unless we have your signed authorization to do so.

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period shall be deactivated per Welfare and Institutions Code Section 14043.62 which reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you have not treated any Medi-Cal patients within a 12-month period your Medi-Cal Dental Program provider number, will be deactivated. If you wish to remain an active provider in the Medi-Cal Dental Program, complete the form below and mail to: Post Office Box 15609, Sacramento, CA 95852-0609. If the form is not received by Denti-Cal prior to the end of the 12-month period, your provider number will be deactivated. ***If your provider number is deactivated, you must reapply for enrollment in the Medi-Cal Dental Program.*** *To request an enrollment package contact Denti-Cal toll free at (800) 423-0507.*

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____
_____.

Check the boxes applicable to your practice:

- ☐ AHK (Alameda Healthy Kids)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care)
  Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care)
  Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____ _____ _____
Provider Name Prov. Number Provider Signature

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Termination of Provider Participation

A provider may terminate his or her participation in the California Medi-Cal Dental Program at any time. Written notification of voluntary termination must include the provider's signature. Send to:

Denti-Cal
California Medi-Cal Dental Program
Provider Services
P.O. Box 15609
Sacramento, CA 95852-0609

Suspended and Ineligible Providers

Billing providers who submit claims for services provided by a rendering provider suspended from participation in the Medi-Cal Dental Program are also subject to suspension from the Program.

Welfare and Institutions (W&I) Code, §14043.61(a) states that "a provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal program for the services, goods, supplies, or merchandise provided, directly, or indirectly, to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List,…or any list is published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and medicaid programs, to identify suspended, excluded, or otherwise ineligible providers."

The List of Excluded Individuals/Entities compiled by the Office of Inspector General is available online at:

http://exclusions.oig.hhs. gov.

Enrollment of Billing Intermediaries

Denti-Cal providers who use a billing intermediary for claims preparation and submission must notify Denti-Cal of their billing arrangements. A billing intermediary may include any entity, such as a partnership, corporation, sole proprietorship or individual, that is contracted with a provider to bill the Denti-Cal program on his or her behalf. A provider's salaried employees are not considered billing intermediaries.

A provider who wishes to use a billing service must complete a Provider Billing Intermediary Notification Form (Figure 2-8) and send it to Denti-Cal. A provider should use this form to notify Denti-Cal of the initiation, renewal or termination of a billing intermediary contract. Billing services submitting claims to Denti-Cal must register with the California Medi-Cal Dental Program by completing a Billing Intermediary Registration Form (Figure 2-9). Upon registration, Denti-Cal will assign a registration number which the billing service must include on all claims submitted. To obtain a Provider Billing Intermediary Notification Form and/or Billing Intermediary Registration Form, providers may call Denti-Cal toll-free at (800) 423-0507 or write to:

Denti-Cal
California Medi-Cal Dental Program
Provider Services
P.O. Box 15609
Sacramento, CA 95852-0609

When a provider notifies Denti-Cal of billing service arrangements, Denti-Cal will acknowledge the notification within 10 days. Denti-Cal will also notify a provider when one of the following occurs:

- A billing intermediary notifies Denti-Cal that it has contracted with a provider;
- A billing intermediary notifies Denti-Cal that it has terminated its contract with a provider;
- A billing intermediary that submits claims for a provider notifies Denti-Cal that it is withdrawing its registration as a Denti-Cal billing intermediary;
- The State of California Department of Health Services instructs Denti-Cal to withdraw the registration of a provider's billing intermediary.

How to Complete the Provider Billing Intermediary Notification Form

Providers must use this form to notify Denti-Cal when they initiate, renew or terminate a contract with a billing intermediary. The form contains the following:

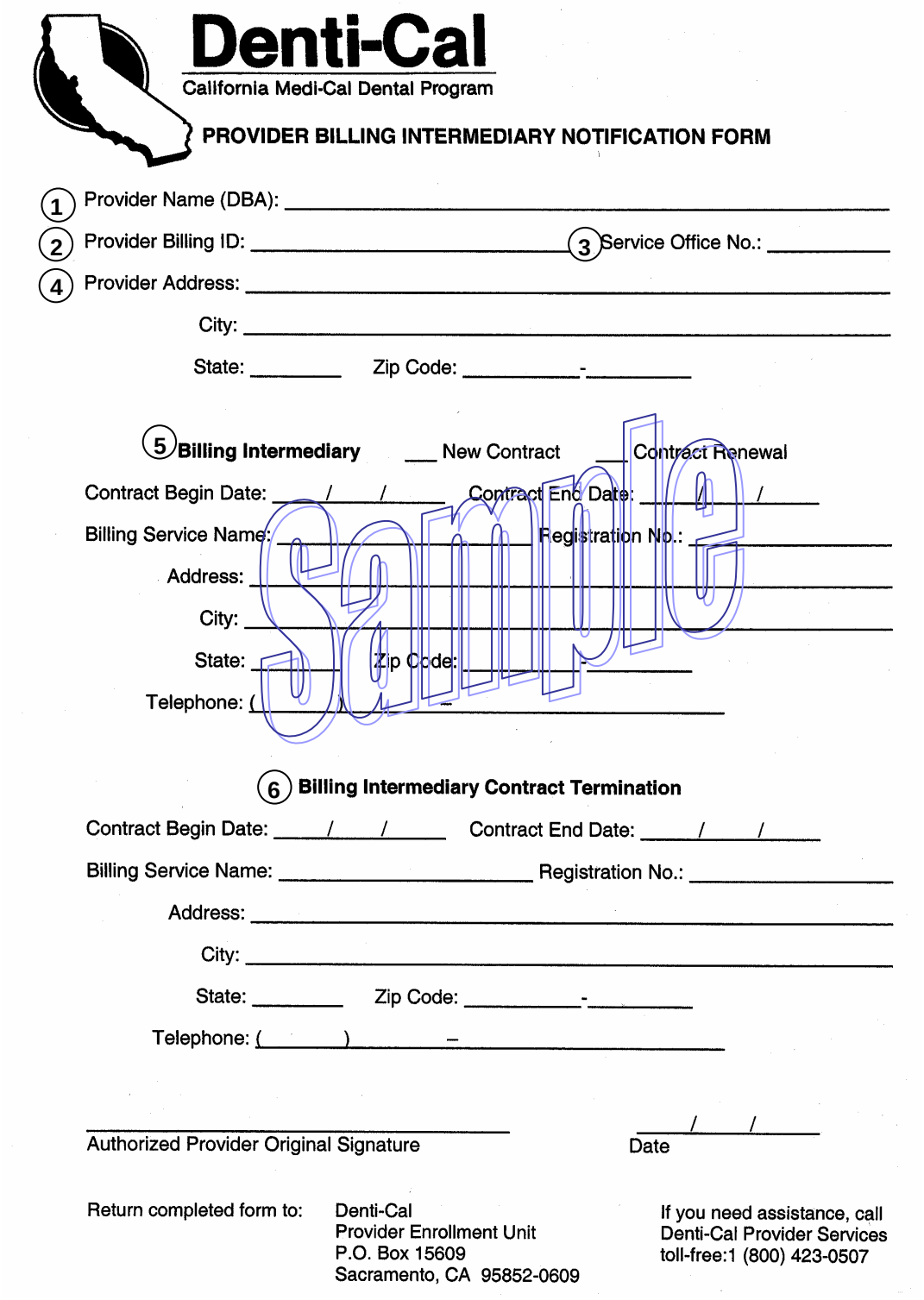
1. **PROVIDER NAME (DBA)**: Enter the provider's "Doing Business As" name.
2. **PROVIDER BILLING ID**: Enter the provider's Denti-Cal identification number.
3. **SERVICE OFFICE NO.**: Enter the number that identifies the provider's service office.
4. **PROVIDER ADDRESS**: Enter the provider's street address, city, state, and zip code in these fields.
5. **BILLING INTERMEDIARY INFORMATION**:

   _____ New Contract
   _____ Contract Renewal

   If you are notifying Denti-Cal of a new or renewed contract with a billing intermediary, place an "X" next to the correct selection and complete the following billing intermediary fields:

   - CONTRACT BEGIN DATE: Beginning date of the contract between the provider and the billing intermediary.
   - CONTRACT END DATE: Date the contract between the provider and billing intermediary will end (unless it is renewed).
   - BILLING SERVICE NAME: Name of the organization that will prepare and submit claims on behalf of the provider.
   - REGISTRATION NO.: The registration number assigned to the billing intermediary, if applicable. (NOTE: The assigned registration number may not yet be available to a provider who is notifying Denti-Cal of a new contract with a billing service, especially if the billing service has not yet registered with Denti-Cal).
   - ADDRESS: Complete the fields for the billing service's address, including street address, city, state and zip code.
   - TELEPHONE: Enter the billing service's telephone number, including area code.
6. **BILLING INTERMEDIARY CONTRACT TERMINATION**: If you are reporting the termination of a contract with a billing intermediary, complete the fields under this section the same as instructed above.

Figure 2-8



Denti-Cal

California Medi-Cal Dental Program

PROVIDER BILLING INTERMEDIARY NOTIFICATION FORM

(1) Provider Name (DBA): _____

(2) Provider Billing ID: _____ (3) Service Office No.: _____

(4) Provider Address: _____

City: _____

State: _____ Zip Code: _____-_____

(5) **Billing Intermediary** ___ New Contract ___ Contract Renewal

Contract Begin Date: ____/____/____ Contract End Date: ____/____/____

Billing Service Name: _____ Registration No.: _____

Address: _____

City: _____

State: _____ Zip Code: _____-_____

Telephone: (_____) _____–_____

(6) **Billing Intermediary Contract Termination**

Contract Begin Date: ____/____/____ Contract End Date: ____/____/____

Billing Service Name: _____ Registration No.: _____

Address: _____

City: _____

State: _____ Zip Code: _____-_____

Telephone: (_____) _____–_____

_____ ____/____/____

Authorized Provider Original Signature Date

Return completed form to: Denti-Cal
Provider Enrollment Unit
P.O. Box 15609
Sacramento, CA 95852-0609

If you need assistance, call
Denti-Cal Provider Services
toll-free:1 (800) 423-0507

How to Complete the Billing Intermediary Registration Form

Billing intermediaries that prepare and submit claims to Denti-Cal on behalf of providers must complete this form as follows and return it to Denti-Cal. Denti-Cal will assign the billing intermediary a registration number, which must be included on all claims submitted to Denti-Cal.

1. **TYPE OF REQUEST**: Billing intermediary should indicate whether this is an initial (new) registration, or if the request is to terminate registration or update (add/delete) the list of providers with whom billing intermediary is contracted.
2. **BILLING SERVICE NAME**: Enter the billing service's "Doing Business As" name.
3. **REGISTRATION NO. AND STATUS**: Enter the billing service's registration number, if applicable. Indicate whether this registration number is a currently-issued number or was previously assigned by Denti-Cal to the billing service for another registration.
4. **MAILING ADDRESS**: Enter the complete address of the billing service, including street address, city, state, ZIP code and telephone number.
5. **LIST DENTI-CAL PROVIDERS CONTRACTED WITH THE BILLING SERVICE**: List the Medi-Cal dental providers who contract with the billing service, including the provider name and Medi-Cal dental provider number and service office. Indicate whether to add ("A") or delete ("D") this provider from the registration and list the beginning date of the contract with each provider listed.
6. **AUTHORIZED APPLICANT'S ORIGINAL SIGNATURE/DATE**: Registration form must be signed with the billing service's original signature (rubber stamps are not acceptable) and dated.

   Return the completed form to:

   Denti-Cal
   California Medi-Cal Dental Program
   Provider Enrollment Unit
   P.O. Box 15609
   Sacramento, CA 95852-0609

Figure 2-9

Denti-Cal

California Medi-Cal Dental Program

BILLING INTERMEDIARY REGISTRATION FORM

(1) Type of Request: ☐ Initial Registration ☐ Terminate Registration ☐ Add Provider (s) ☐ Delete Provider (s)

(2) Billing Service Name: _____

(3) Registration No. and Status: _____ ____ Current ____ Previous

(4) Mailing Address:

Name: _____

Street: _____

City: _____

State: _____ ZIP Code _____ – _____

Telephone: (_____) _____ – _____

(5) List Denti-Cal Providers contracted with the Billing Service:

Provider Name (DBA) Provider ID/Service Office Number	Action: A = Add D = Delete	Action Effective Date
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

_____
Authorized Applicant's Name (Please Print)

(6) _____ Date: ____/____/____
Authorized Applicant's Original Signature

Return completed form to: Denti-Cal
California Medi-Cal Dental Program
P.O, Box 15609
Sacramento, CA 95852-0609

DC 156 (12/00)

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Electronic Claims Submission and Payment Services

To submit documents and receive corresponding reports electronically, dentists who have enrolled and are certified to participate in the California Medi-Cal Dental Program must apply and be approved by Denti-Cal to participate in the EDI program. The Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement (for electronic claim submission), hereinafter "Trading Partner Agreement," must be signed and submitted along with the Provider Service Office Electronic Data Interchange Option Selection Form. Failure or refusal to sign this Agreement may be grounds for immediate suspension from participation in the electronic claims submission program pursuant to Title 22, California Code of Regulations (CCR) §51502.1(j). This Agreement is also required for EDI clearinghouses and billing intermediaries billing electronically on behalf of Denti-Cal providers.

When a provider is enrolled in the Denti-Cal EDI program, Denti-Cal sends the provider a letter confirming the provider's EDI enrollment.

Section 3 of this *Denti-Cal Provider Manual* gives instructions for completing all required billing forms. Denti-Cal's Electronic Data Interchange (EDI) service gives participating providers the option of submitting many of these completed treatment forms electronically to Denti-Cal and receiving related information by computer.

HIPAA-Compliant Electronic Format Only

Denti-Cal accepts only the HIPAA-compliant electronic format for claims (ASC X12N 837) and claim status (ASC X12N 276) from certified trading partners. A provider submitting claims electronically is required to undergo certification for the HIPAA-compliant format. However, if a provider is submitting claims electronically through its contracted clearinghouse, only the clearinghouse must be certified. In this case, a provider must ensure that its contracting clearinghouse has been certified through Denti-Cal, prior to submitting claims.

Ineligibility for EDI

A Denti-Cal provider is not eligible for EDI if, within the past three years, criminal charges were filed against the provider for fraudulently billing the Medi-Cal program, or if the provider has been suspended from the Medi-Cal program, placed on prior authorization or special claims review, or has been required to pay recovery to Medi-Cal for overpayments in excess of 10 percent of the provider's total annual Medi-Cal income.

A copy of the Denti-Cal EDI Companion Guide, as well as the Trading Partner Agreement, can be obtained by phoning Provider Services toll-free at (800) 423-0507 or (916) 853-7373 and asking for EDI Support. Requests may also be sent by e-mail to denti-caledi@delta.org.

Figure 2-10

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF HEALTH SERVICES

MEDI-CAL DENTAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT
(For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES
This agreement is between the State of California, Department of Health Services, hereinafter referred to as the "Department" and:

PROVIDER INFORMATION			
Provider name (full legal)			
DBA (if applicable)	Provider number		
Provider service address (number, street)	City	State	ZIP Code
Contact person			
Contact person address (number, street)	City	State	ZIP Code
Contact telephone number ( )	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
BILLER INFORMATION (If other than the provider of service)			
Biller name (full legal)	Biller telephone number ( )		
DBA (if applicable)			
Business Address (number, street)	City	State	Zip
Contact Person	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		

Full legal name(s) required as well as any assumed (DBA) names(s), address(es), and Medi-Cal Dental provider number(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."

1.1 ELECTRONIC DATA INTERCHANGE (EDI) DATA TYPES
This Agreement applies to the following EDI Data Types, when available: (Refer to Provider Service Office Electronic Data Interchange Option Selection Form)
ANSI X 12 837 (Claims/TARs/RTDs/NOAs/Adjustments)
ANSI X 12 276/277 (Claim Status Inquiry/Responses)
ANSI X 12 278 (Treatment Authorization Requests/Responses)
ANSI X 12 835 (Claim Payment/Remittance Advice)

1.2 BACKGROUND INFORMATION
The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal Dental electronic Biller.

2.0 DEFINITIONS
The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term "electronic" or "electronically," when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING
The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Denti-Cal provider manual. The Provider hereby acknowledges that he or she has received, read, and understands the provider manual and its contents, and agrees to read and comply with all provider manual updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION
The Provider agrees by claims submission and certifies under penalty of perjury that all services for which claims are submitted electronically have been personally provided to the patient by the Provider or under his or her direction by another person eligible under the Medi-Cal program to provide such services, and such person(s) are designated on the claim. The Provider also certifies by claims submission that the services were, to the best

Figure 2-11

PROVIDER SERVICE OFFICE
ELECTRONIC DATA INTERCHANGE
OPTION SELECTION FORM

Please check one of the following:

_____ Begin Registration _____ Terminate Registration _____ Change Options

Provider Name (DBA): _____

Denti-Cal ID: _____ Service Office: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone Number: _____

Software/Practice Management System: _____

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
For assistance, contact EDI Support at (916) 853-7373.

INPUT FROM: _____ Service Office (SO)
_____ Billing Office (BO)
_____ Clearing House (CH) (Name: _____)

****** YOUR VENDOR WILL ASSIST YOU IN COMPLETING THE FOLLOWING ******

Unique Clearing House ID# Required? YES NO
Submitter ID#:_____
Provider ID#:_____ Provider Site ID#:_____

You will submit Claims, TARs and Adjustments (ANSI X 12 837). When available, you will submit TARs (ANSI X 12 278).
Will you also submit: RTDs electronically? YES NO
NOAs electronically? YES NO
Claim Status Inquiry (ANSI X 12 276)? YES NO

RETURN OUTPUT OPTIONS when available (standard options are shaded):

EDI Document	Requested? (Circle One)		Send To (Circle One)		
Electronic RTDs	**YES**	NO	SO	BO	CH
Electronic NOAs	**YES**	NO	SO	BO	CH
Electronic EOB Supplemental Claim Data (If YES, CIRCLE ONE: SUMMARY or DETAIL)	YES	NO	SO	BO	CH
Electronic X-Ray/Attachment Labels (CIRCLE ONE: 1-UP or 3-UP)	**YES**	NO	SO	BO	CH
Report of Documents Awaiting Return Information (CP-0-978-P)	**YES**	NO	SO	BO	CH
Report of EDI Documents Received (CP-0-973-P)	**YES**	NO	SO	BO	CH
Remittance Advice (ANSI X 12 835)	YES	NO	SO	BO	CH
Claim Status Inquiry Response (ANSI X 12 277)	YES	NO	SO	BO	CH
Treatment Authorization Request & Response (ANSI X 12 278)	YES	NO	SO	BO	CH

_____ _____
Authorized Applicant's Original Signature Date

FOR DENTI-CAL USE ONLY	
C/H ID:	
Remote ID:	
P/W:	
CV:	

Return completed form to:

Medi-Cal Dental Program
Provider Services
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609

OPTSELCT (Rev. 08/04)

Electronic Data Interchange (EDI)

Submitting claims electronically reduces processing time for claims, makes billing and tracking documents easier, and helps maximize computer capabilities. EDI-enrolled providers can also receive the Notice of Authorization (NOA) and Resubmission Turnaround Document (RTD) forms electronically along with other EDI reports.

For an EDI Enrollment Packet, please contact Provider Services toll-free at (800) 423-0507. For an EDI How-To Guide or other information on submitting Denti-Cal claims and Treatment Authorization Requests (TARs) electronically, please call EDI Support at (916) 853-7373. Requests may also be sent by e-mail to denticaledi@delta.org.

A dental office wishing to use EDI must have a computer system that includes a modem to connect the computer to the telephone lines and a software program that will allow the transmission of claims. If the office already has a computer, check with the practice management system vendor to determine if the software will enable submitting of claims electronically to Denti-Cal. The software vendor can also assist in determining the best computer hardware and software options for electronic claims processing needs.

The office computer, modem and software can enable use of EDI to send Treatment Authorization Requests (TARs), claims and Notices of Authorization (NOAs) for payment, reevaluation requests over the telephone line directly from the office to Denti-Cal, or through a billing intermediary or clearinghouse. In addition, an office can respond to Resubmission Turnaround Documents (RTDs) by electronically transmitting the corrected information needed to process the claim. Electronic Data Interchange gives providers the option of receiving claims-related information electronically from Denti-Cal, such as reports and Explanation of Benefits data for performing automated accounts receivable reconciliation. The EDI system format also allows the electronic submission of comments which may be pertinent to the treatment requested or provided. Denti-Cal provides identification labels and specially marked envelopes for mailing additional information (such as x-rays, periodontal charting, or other documentation) which may be required to process electronically submitted treatment forms.

Use red-bordered EDI envelopes and EDI labels only when Denti-Cal requests them through the "X-Ray/Attachment Request" report (CP-O-971-P).

Use green-bordered envelopes when submitting claims, NOAs and RTDs (conventional paper forms) or those made available electronically that are printed onto paper and mailed in for processing as well as Claim Inquiry Forms. No EDI labels on EDI RTDs or NOAs, please.

Use blue-bordered envelopes when submitting conventional paper TARs.

What can be sent electronically to Denti-Cal:

Claims, TARs and, if the system or clearinghouse can accept them, NOAs for payment when treatment is completed (currently, only selected software and clearinghouses include the EDI NOA feature). Mail completed RTDs (even those provided electronically that are printed on paper), NOAs (if the system cannot submit them electronically), requests for re-evaluation, and Claim Inquiry Forms (CIFs).

Be sure EDI claims and TARs are being received by Denti-Cal:

Within 24 to 48 hours after sending documents electronically, Denti-Cal provides an acknowledgement report to confirm receipt of claims and TARs (CP-O-973-P: Daily EDI Documents Received Today). Another report (CP-O-971-P: X-Ray/Attachment Request) is issued the same day the acknowledgement report is issued if documentation is needed. If these reports are not being received, check with your vendor, clearinghouse, or EDI Support.

How to send x-rays and attachments:

Be sure to have a supply of EDI labels and envelopes (small and large x-ray envelopes, and mailing envelopes) which are printed in red ink. When entering the document into the system, determine whether x-rays or documentation are needed. If so, take a moment at that time to prepare EDI labels and envelopes:

- Insert the x-rays into an EDI x-ray envelope.
- Affix a blank label onto the outside of the envelope.
- Staple any necessary documentation such as a Justification of Need for Prosthesis form (DC-054) onto the outside of the x-ray envelope.
- Write the patient's name under "Patient Meds ID" to help you identify the patient.

When you receive the X-ray/Attachment Request report, simply write the 11-digit Base DCN next to "Denti-Cal DCN" and mail it to Denti-Cal in the large mailing envelope marked with the special EDI post office box.

Claims information that is transmitted electronically to Denti-Cal is delivered to Denti-Cal's computer system for processing. Denti-Cal providers may use EDI to submit treatment forms and receive reports and other electronic data 24 hours per day Monday through Saturday, and from 12 noon to 12 a.m. on Sunday (excluding holidays). Electronic documents received at Denti-Cal by 3:45 p.m. Monday through Friday are entered into EDI processing the same evening.

Denti-Cal EDI Support staff help vendors in developing a computer system to meet the technical requirements of EDI processing. Staff are also available to answer EDI-related questions and assist with any problems an office may be experiencing with electronic claims transmission.

To enroll in EDI, call the Provider Support Services Enrollment Unit toll-free at (800) 423-0507. EDI Support may be reached at (916) 853-7373.

Medi-Cal Dental
Patient Referral Service

Medi-Cal Dental providers can take advantage of a free referral service for accepting Medi-Cal dental patients. This referral service can be an excellent resource for enrolled Denti-Cal providers to build, maintain or increase their patient base while making available the highest level of dental service for the state's medically needy.

If you are a provider interested in this service, or need to update the information currently on file, please phone (800) 423-0507 and ask for the Medi-Cal Dental Patient Referral Service Form (a sample is found on the following page), and mail it to:

California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609

Denti-Cal
California Medi-Cal Dental Program

Figure 2-12

Medi-Cal Dental Patient Referral Service

Dear Doctor:

The Medi-Cal Dental Program (Denti-Cal) offers a voluntary patient referral service that serves the dental community statewide. Please consider our request to include your office on our referral list for Medi-Cal Dental patients.

Complete this form and return it to Denti-Cal in the enclosed envelope.

If you have any questions about the Medi-Cal Dental Patient Referral Service, please do not hesitate to call us toll-free (800) 423-0507.

Sincerely,
Provider Services
Medi-Cal Dental Program
Denti-Cal

☐ Yes I would like Medi-Cal Dental patients referred to my office. Please add my name to your referral list. I understand I may request removal of my name from this list at any time.

☐ No I do not want Medi-Cal Dental patients referred to my office. Please do not include my name on your referral list.

Provider Name: _____ Billing Provider ID: _____ Service Office #: _____

Business Name: _____

Fictitious Name: _____

Office Address: _____

Office Telephone: ( ) _____ Is your office wheelchair accessible? ☐ Yes ☐ No

What other languages are spoken in your office? _____

List any dental specialties or services offered in your office (e.g., endodontic, periodontal, oral surgical procedures, general anesthesia, etc.): _____

What age group of children does your office see? ☐ 5 & under ☐ 6 – 12 ☐ 13 & older

Billing Provider Signature: _____ **Date:** _____

Direct Deposit of Payment

Direct Deposit of Payment

Denti-Cal offers direct deposit of your Denti-Cal payments to your checking or savings account. To begin participating in direct deposit, you must complete and sign a Direct Deposit Enrollment Form. You may request a form by calling Provider Services at (800) 423-0507, or by writing to Denti-Cal at this address:

Denti-Cal
California Medi-Cal Dental Program
Provider Services
P.O. Box 15609
Sacramento, CA 95852-0609

Instructions for completing the Direct Deposit Enrollment Form are contained on the back of the form. Mail the completed form to Denti-Cal at the address shown above. Please be sure to sign and date the form; the Direct Deposit Enrollment Form must contain the provider's original signature to be accepted for processing.

Upon receipt of your Direct Deposit Enrollment Form, Denti-Cal will make sure your bank participates in electronic funds transfer. To verify your account information, we will send a "test" deposit to your bank; you will notice a "zero" deposit to your account for that payment date. The direct deposit process usually takes three to four weeks to complete. Of course, during this time you will continue to receive your Denti-Cal payment checks through the mail.

Each time we deposit a payment directly to your account, a statement confirming the amount of the deposit will appear on your Explanation of Benefits.

Remember to contact Denti-Cal if you wish to change or discontinue direct deposit of your Denti-Cal payment checks. If you change banks or close your account, you must provide Denti-Cal with written authorization to discontinue direct deposit of your Denti-Cal checks.

Figure 2-13a

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

DIRECT DEPOSIT ENROLLMENT FORM

1. New Enrollment ☐ Change Enrollment Information ☐ Discontinue Enrollment ☐

2. Provider Information:

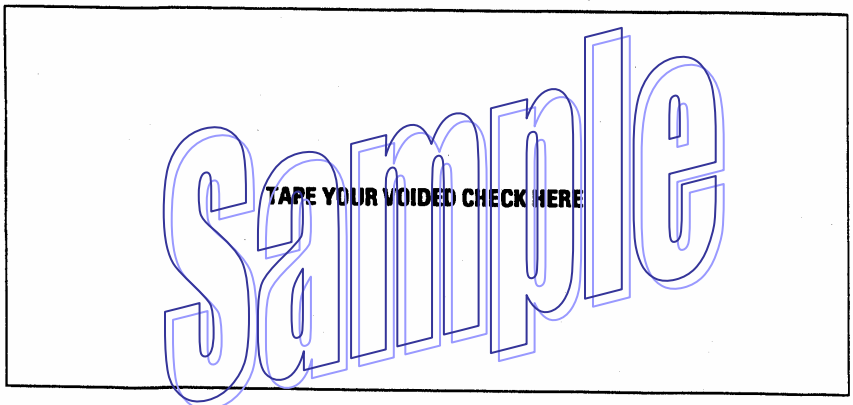
   Provider Number: _____ Provider Service Office: _____

   Provider DBA Name: _____

   Provider's name as shown on bank account: _____

3. Banking Information:

   Please attach a VOIDED check from your bank account to this form in the space below:



   Type of Account:

   ☐ Checking ☐ Savings

4. Discountinued Enrollment:

   Reason for Discontinued Enrollment: _____

5. Provider's Signature:

_____ _____
Provider's Signature (Requires Provider's Original Signature) Date

DO NOT WRITE BELOW THIS LINE

For Office Use Only

Date Entered: _____ Initials: _____

Denti-Cal 137 (7/95)

Figure 2-13b

Instructions for Completing the Direct Deposit Enrollment Form

1. Check "New Enrollment," "Change Enrollment Information" or "Discontinue Enrollment".
2. Fill in your Denti-Cal Provider Number, Service Office Number, "Doing Business As" Name and the name shown on the bank account records.
3. Attach a VOIDED check to the form. Tape it to the blank space provided. Check the appropriate box for "Checking" or "Savings" to indicate the type of bank account.
4. For discontinued enrollment only: Fill in your reason(s) for discontinued enrollment.
5. Sign your name and fill in date. The **provider's original signature** is required. Rubber stamp signatures or initials cannot be accepted.
6. Send completed form to: **Denti-Cal/Enrollment Unit**
   California Medi-Cal Dental Program
   P.O. Box 15609
   Sacramento, CA 95852-0609

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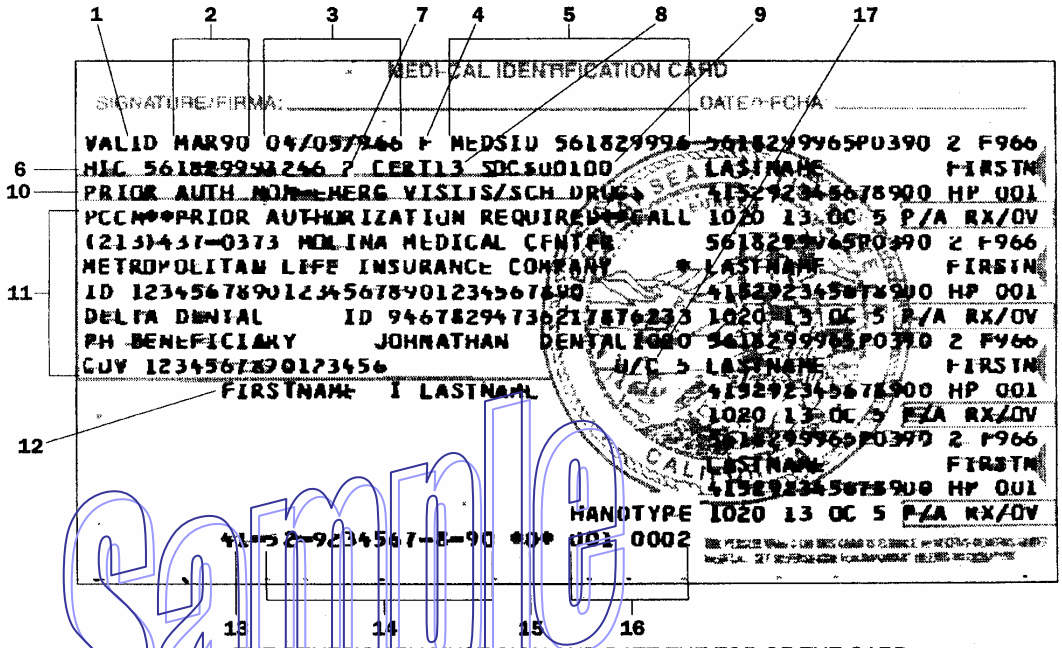
Figure 2-14
IMMEDIATE NEED CARD – STATE ISSUED (MC-302)



THE BENEFICIARY MUST SIGN AND DATE THE TOP OF THE CARD

NOTE: The county-produced MC-302 Immediate Need Card can be identified by the word "HANDTYPE" which will be present in the county use area (field 16).

1. Valid Card or Retro Card Indicator
2. Month and Year of Eligibility
3. Date of Birth, mm/dd/cyy; c = century
4. Sex
5. MEDS ID (9-digit Social Security Number or pseudo-MEDS ID)
6. Medicare Billing Number (Health Insurance Claim Number, Railroad Retirement Board Number or Social Security Number)
7. Medicare Status Indicator
8. Share-of-Cost Certification Day or Share-of-Cost Percent Obligation
9. Share-of-Cost Amount
10. Service Restriction Printed Message Area
11. Floating Restriction/Coverage Area*
12. Beneficiary Name
13. Beneficiary County ID
14. Beneficiary ID
15. Beneficiary ID Check Digit Area
16. County Use Area
17. O/C Other Coverage Codes (see Section 5 of this manual)

* This area is used to identify hospice coverage, restricted aid code messages , health care plans, other health coverage, and dental coverage.

The Medi-Cal Benefits Identification Card

Beneficiary Identification

Denti-Cal does not determine the eligibility of beneficiaries. Eligibility for the California Medi-Cal Dental Program is determined by a County Social Services office and reported to the State of California. The State, in turn, issues a Medi-Cal Benefits Identification Card (BIC) (see Figure 2-15 four pages following) to beneficiaries who are eligible for Medi-Cal benefits. The BIC serves as a permanent identification for a Medi-Cal beneficiary; however, possession of the card does not guarantee eligibility for Medi-Cal benefits, since the card can be retained by the beneficiary whether or not the beneficiary is eligible for the current month.

In certain instances, such as immediate need, a Medi-Cal beneficiary will be issued a hand-typed paper card as proof of eligibility. The MC-302 Immediate Need Card (see Figure 2-14 on the preceding page), is issued manually by the county and can be identified by the word "HANDTYPE" located in the bottom right corner of the card. The beneficiary must certify to the county that there is a medical need for this card and that the provider will not perform treatment without a valid Medi-Cal card.

A beneficiary may be issued an MC-302 identification card with service restrictions. Restricted service messages are enclosed within a green-bordered area located on the card immediately above the beneficiary's name. The beneficiary must sign and date the card at the top, where indicated.

The provider is required to make a "good-faith" effort to verify the beneficiary's identification by matching the name and signature on the BIC to that on a valid photo identification, such as:

- For an adult: a California driver's license or identification card;
- For a school-age child: a school identification card with photo;
- For a child who is too young to attend school: a notarized statement accompanied by a copy of a parent's or guardian's identification card;
- For a disabled person in a convalescent facility: a statement from a charge nurse on official letterhead from the facility verifying the beneficiary's identity.

The provider must retain a copy of this identification in the beneficiary's records. If there is a conflict in the beneficiary's Denti-Cal billing history where a provider bills or submits for authorization for a procedure that was previously performed by another provider, Denti-Cal will request that the current provider submit a copy of the beneficiary's identification to verify that the services are being provided to the appropriate beneficiary. If this situation occurs and the current provider cannot provide appropriate beneficiary identification, payment or authorization for treatment will be denied.

Altered Cards and Other Abuses of the California Medi-Cal Dental Program

The Department of Health Services is requesting that dental providers be reminded that all beneficiary information is confidential and must be protected from disclosure to unauthorized personnel. Beneficiary identification includes the beneficiary's name, address, telephone number, social security number and Medi-Cal identifi-cation number. Protecting confidential information is especially important for providers of in-patient care billing and third-party insurance organizations when utilizing independent billing agencies, as well as employees who appear to be inappropriately accessing such information.

Dental providers should not accept any Medi-Cal identification card that has been altered in any way. If a beneficiary presents a paper or plastic card that is photocopied or contains erasures, strike-outs, white-outs, type-overs, or appears to have been altered in any other way, the provider should request that the beneficiary obtain an unaltered card from his or her county social services office prior to performing services. Health care providers are encouraged to report evidence of fraud to the Attorney General's Medical Fraud Hotline at (800) 722-0432. Any provider who suspects a beneficiary of abusing the California Medi-Cal Dental Program may call (800) 822-6222. Situations where abuse of the program may be suspected include:

- Use of another person's Medi-Cal identification card;

- Presenting an altered card;
- Attempting to obtain excessive or inappropriate drugs.

Misuse of Benefits Identification Card: New BICs Issued

The Department of Health Services (DHS) Medical Review Branch has increased the number of replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused. Approximately 10,000 beneficiaries per month will be issued BICs with new Identification (ID) numbers and issue dates. This process may be further escalated as other misuses of BICs are discovered.

When verifying eligibility for the beneficiaries who receive new cards, the Automated Eligibility Verification System (AEVS) will return the eligibility message, "For claims payment, current BIC ID number and date of issue required." Providers must have and use the BIC ID number and issue date from the new card when verifying beneficiary eligibility. All providers must have and use the BIC ID number and issue date from the new card when submitting claims for reimbursement. If the BIC ID number and issue date of the new card are not on the claim for beneficiaries whose card returns the message, "For claims payment, current BIC ID number and date of issue required," the claim will be denied.

A claim for payment on behalf of a beneficiary that returns the new eligibility message must include the new BIC ID number and issue date (mmddyy) as follows:

- Paper claims – new BIC ID in Patient Social Security Number (SSN) field (field 2) and new issue date in the Proof of Eligibility (POE) field;
- EDI claims – new BIC ID in SSN field and new issue date in the Comments field; and
- Attaching a copy of the BIC card for documentation purposes will not be accepted.

For automated messages providing eligibility information, phone the Automatic Eligibility Verification System (AEVS) at (800) 456-2387 and, when prompted, enter the information found on the BIC ID. For assistance with the eligibility message, the Point of Service (POS) device or the Medi-Cal Web site, call the POS/Internet Help Desk at (800) 541-5555. If illegal use of a BIC is suspected, or if you have any questions about this policy, call Provider Services at (800) 423-0507.

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Medi-Cal BIC Numbers

Medi-Cal now issues new BICs with a 14-character alphanumeric identification (ID) number. The state-wide phase-in of these new cards is scheduled for completion by July 1, 2005. Current BICs have either a 10-character numeric or a 10-character alphanumeric ID number.

The new BIC has a 14-character alphanumeric comprised of a nine-character alphanumeric, a check digit and a four-digit Julian date matching the issue date of the BIC. The new ID will be processed the same way as the 10-character alphanumeric BIC ID. Once these cards are distributed statewide, the 10-digit ID numbers will be phased out.

Current billing and eligibility verification practices are not affected at this time.

Note: Providers are responsible for verifying the beneficiary's identity and eligibility prior to rendering services.

How do you know if a Medi-Cal beneficiary has a valid BIC?

Providers will need to submit an eligibility verification transaction using the information on the BIC presented by the Medi-Cal beneficiary.

- If the BIC is not valid, the eligibility verification system will return one of the following messages: "Invalid BIC ID," or "Issue Date of the Beneficiary's ID Card Invalid."
- If the eligibility verification transaction returns the message "Invalid BIC ID," do the following:
  - Make sure the information was entered correctly.
  - If the information was entered correctly, refer the beneficiary to their local county office.
- Until the statewide reissuance is complete in July, some Medi-Cal beneficiaries will have a BIC with a 10-character ID and others will have a BIC with a 14-character ID.
- Medi-Cal beneficiaries will need to use the 10-character BIC until the 14-character BIC is received in the mail.
- Once beneficiaries have received the new 14-character BIC ID, the old one will be deactivated.
- If beneficiaries have not received the new 14-character BIC ID by August 2005 and are getting the "Invalid BIC ID" message, refer them to their local county office.

Providers are responsible for verifying the beneficiary's identity and eligibility for services. Eligibility should always be verified prior to rendering service by using information from the Medi-Cal beneficiary's BIC ID.

How will the new 14-character BIC ID work?

Until the statewide reissuance is complete in July, the new 14-character BIC ID will be treated the same as the current 10-character BIC ID.

The Automated Eligibility Verification System (AEVS) will accept all 14 characters, however only the first 10 characters will be returned with the eligibility verification response. After the statewide reissuance is complete, AEVS will be changed to return the full 14 characters of the BIC ID with the eligibility verification response.

The Medi-Cal Dental Program (Denti-Cal) Interactive Voice Response (IVR) System now accepts nine of the 14-character BIC ID. When using the Denti-Cal IVR, enter those first nine digits *only* as the prompt for date of birth follows immediately thereafter.

Will the 10-character BIC ID and Social Security Number (SSN) continue to be accepted for billing?

- The claims processing system will accept all 14 characters, however only the first 10 characters will be processed. Providers should bill using the ID number from the BIC for which they received an eligibility verification response.
- The 10-character BIC ID will be phased out after the statewide reissuance is complete.
- Denti-Cal providers can continue to use the SSN for billing until notified of the new billing requirements by Denti-Cal.

- For some beneficiaries, providers must have and use the BIC ID and issue date for verifying eligibility and billing.
- When providers attempt to verify eligibility for beneficiaries using the SSN or previous BIC number, the eligibility verification system will return the eligibility message, "For claims payment, current BIC ID number and date of issue required."
- New billing requirements will not be implemented until late 2005 or early 2006. More billing information will be released in a future bulletin. Until then, the claims processing system will accept both the 10- and 14-character BICs.

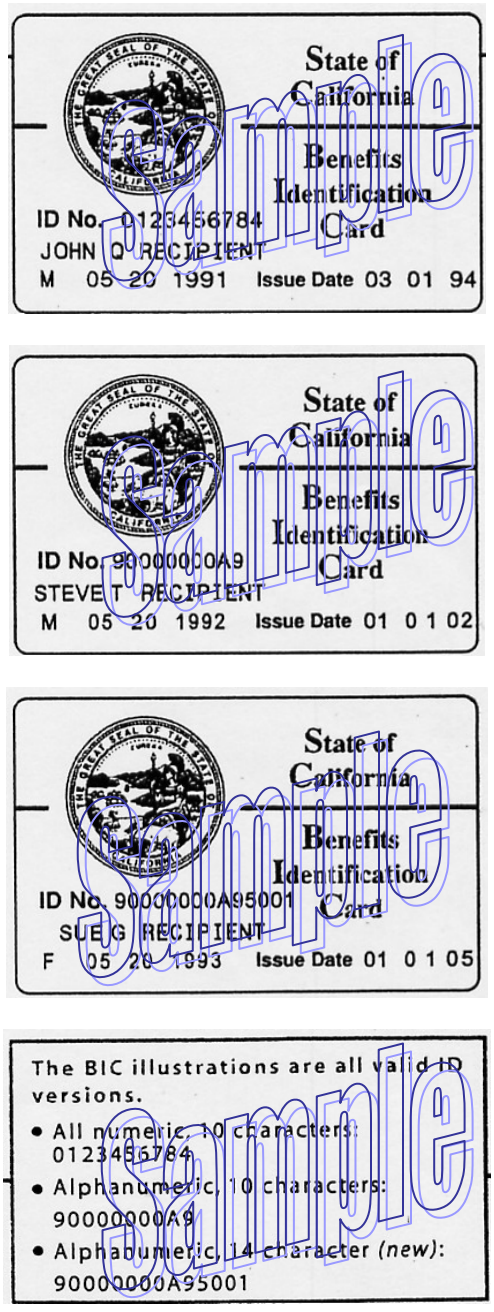
All recent updates are in the Technical Specification Manual on the Medi-Cal Web site at www.medi-cal.ca.gov.

A variety of methods allow providers to verify beneficiary eligibility. For automated messages providing eligibility information, phone the Automatic Eligibility Verification System (AEVS) at (800) 456-2387 and, when prompted, enter the information found on the BIC ID. For assistance with the eligibility message, the Point of Service (POS) device or the Medi-Cal Web site, call the POS/Internet Help Desk at (800) 541-5555.

For additional information regarding the Medi-Cal Benefits Identification Card, please refer to surrounding pages of this section of the *Denti-Cal Provider Manual* or phone (800) 423-0507.

Figure 2-15

MEDI-CAL BENEFITS IDENTIFICATION CARD



Special Project Identification Cards

Some Medi-Cal beneficiaries may be enrolled in special projects, such as prepaid health plans and pilot projects. A beneficiary enrolled in one of these plans who is eligible for dental services should have an identification card from the plan as well as possess a Medi-Cal Benefits Identification Card. A list of current special project and prepaid health plan codes can be found in Section 5 of this manual.

Child Health and Disability Prevention (CHDP) Gateway

On July 1, 2003, Child Health and Disability Prevention (CHDP) medical providers (not dental providers) began pre-enrolling eligible low-income children under 19 years of age into the new CHDP Gateway. CHDP Gateway providers encourage parents to apply for health care coverage for their children through Medi-Cal or Healthy Families. The children are eligible to receive **full-scope, fee-for-service Medi-Cal and Denti-Cal benefits** during the month of application and the following month, or until the processing of their application is complete. **Denti-Cal reimbursement rates for children eligible for this temporary coverage are the same as the usual Denti-Cal rates.** Children who are not eligible for either program will continue to receive CHDP services in accordance with the CHDP periodicity table. CHDP benefits do not include dental benefits. **Aid Codes 8W and 8X are eligible for full scope and Aid Code 8Y is CHDP only, with no dental services available.**

The CHDP Gateway was first described in Denti-Cal Bulletin Volume 19, Number 10 (March 2003). Please refer to that Bulletin for additional information about the Gateway. Since the Gateway began, several issues have arisen that may be of interest to Denti-Cal providers:

- Because some children may be eligible for only 1-2 months, it is very important for children with temporary Medi-Cal eligibility to be seen as quickly as possible. A number of offices and clinics have responded by setting aside a block of time to see these children.
- Children enrolled through the Gateway will ordinarily receive their BIC ID card within 10 days of enrollment. In the interim, they will have an "immediate eligibility document," which will be either a copy of a printout from an Internet website or a Point of Service (POS) device receipt similar to a gas station pump receipt. This document displays the beneficiary's BIC ID number and **is an acceptable form of identification that should be accepted** until the BIC ID card is received. **Regardless of whether the beneficiary presents a BIC ID card or a paper immediate eligibility document, *all providers, including Children's Treatment Program (CTP) providers*, must always check a beneficiary's eligibility status at each visit. *The PM160 form is insufficient documentation for participation in the CHDP Gateway.*** Examples of the Internet and POS device documents are found on the following page.
- The immediate eligibility document can contain several different messages, so it is important to read the response messages carefully. ***All providers participating in the CHDP Gateway, including CTP providers, must check eligibility for every beneficiary at every visit, regardless of what the response message says. The PM160 form is insufficient.***
- Beneficiaries with messages that say, "You are temporarily eligible for full scope Medi-Cal through..." should be treated like any other full scope Medi-Cal beneficiary (**but still check eligibility**).
- For example, beneficiaries with messages that say, "You are temporarily eligible for CHDP services through..." do **not** have full scope Medi-Cal services. They are only eligible for CHDP and emergency Medi-Cal services. Those with emergency Medi-Cal eligibility may be eligible for some dental benefits, which you can determine by checking their aid code and referring to your Denti-Cal Provider Manual. Those who are only eligible for CHDP services (i.e., those who are not eligible for full scope Medi-Cal or Healthy Families coverage) should be referred back to the local CHDP program (see below) to learn about other dental programs that may be available to them. ***Again, Aid Codes 8W and 8X are eligible for full scope and Aid***

Code 8Y is CHDP only, with no dental services available.

- Children who are determined ineligible for temporary Medi-Cal coverage through the Gateway may be assigned other emergency or pregnancy-related Medi-Cal aid codes. If a child must switch dentists because they were unable to complete treatment prior to termination of their temporary Medi-Cal coverage, we encourage you to provide the child's treatment plan and radiographs to their new dentist to prevent unnecessary duplication of costs.
- Because of the short period of eligibility for some children, it will be helpful if you allow your name and phone number to be distributed to CHDP medical providers. If you are willing to do this, please call your local CHDP office to be included on a referral list. You can find your local CHDP office at www.dhs.ca.gov/pcfh/cms/chdp/directory.htm. Also, if you are able to accommodate children eligible for the Gateway on short notice, and there are CHDP medical providers you deal with routinely, it will help to let them know that you are willing to see these children relatively quickly. You may even wish to leave your business card with these providers as a reminder.

Figure 2-16

Example of an Immediate Eligibility Document from the Internet

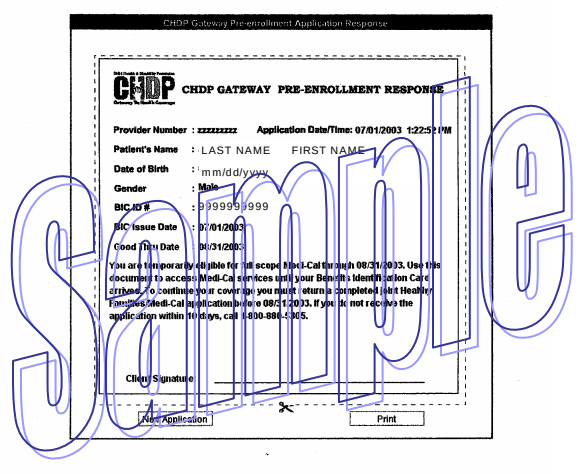
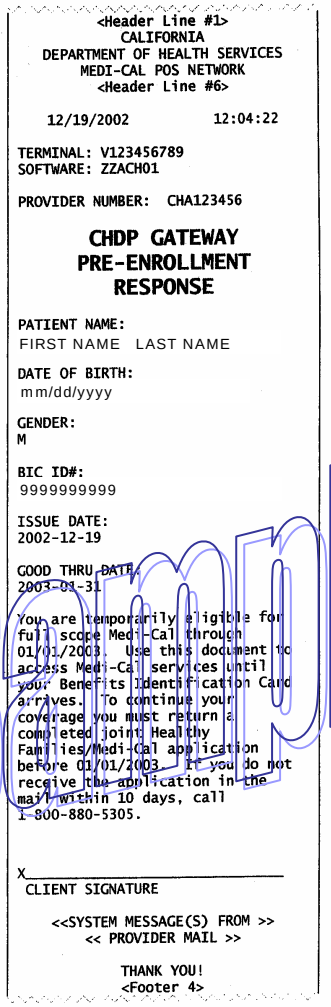


Figure 2-17

Example of an Immediate Eligibility Document from a POS Device



Beneficiary Eligibility

A Medi-Cal beneficiary is eligible for dental services provided under the California Medi-Cal Dental Program. However, limitations or restrictions of dental services may apply in certain situations to the following individuals:

- Those enrolled in a prepaid health plan which provides dental services;
- Those enrolled in another pilot program which provides dental services;
- Those who are assigned special aid codes;
- Those with minor consent restricted service cards.

According to state law, when a provider elects to verify Medi-Cal eligibility using a BIC, a paper identification card or a photocopy of a paper card and has obtained proof of eligibility, he or she has agreed to accept the beneficiary as a Medi-Cal beneficiary and to be bound by the rules and regulations of the Medi-Cal dental program.

A person is considered a child until the last day of the month in which his/her 18th birthday occurs. After that particular month, he/she is considered an adult. However, a treatment plan authorized for a child is effective until completion if there is both continuing eligibility and dental necessity, regardless of change in age status.

Beneficiaries who cannot sign their name and cannot make a mark (X) in lieu of a signature because of a physical or mental handicap will be exempt from this requirement. Beneficiaries who can make a mark (X) in lieu of a signature will not be exempted from this requirement and will be required to make their mark on the Medi-Cal identification card. In addition, the signature requirement does not apply when a beneficiary is receiving emergency services, is 17 years of age or younger, or is a beneficiary residing in a long-term care facility.

If Medi-Cal eligibility is verified, the provider may not treat the beneficiary as a private-pay beneficiary to avoid billing the beneficiary's insurance, obtaining prior authorization (when necessary) or complying with any other program requirement. In addition, upon obtaining eligibility verification, the provider cannot bill the beneficiary for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or share of cost. Providers cannot bill beneficiaries for private insurance cost-sharing amounts such as deductibles, co-insurance or copayments.

Once eligibility verification has been established, a provider can decline to treat a beneficiary only under the following circumstances:

- The beneficiary has refused to pay or obligate to pay the required share of cost.
- The beneficiary has limited Medi-Cal benefits and the requested service(s) is not covered by the Medi-Cal dental program.
- The beneficiary is required to receive the requested service(s) through a designated health plan. This includes cases in which the beneficiary is enrolled in a Medi-Cal managed care plan or has private insurance through a health maintenance organization or exclusive provider network and the provider is not a member provider of that health plan.
- The provider is unable to provide the particular service(s) that the beneficiary requires.
- The beneficiary is not eligible for Medi-Cal dental services.
- The beneficiary is unable to present corroborating identification with the BIC to verify that he or she is the individual to whom the BIC was issued.

A provider who declines to accept a Medi-Cal beneficiary must do so before accessing eligibility information except in the above circumstances. If the provider is unwilling to accept an individual as a Medi-Cal beneficiary, the provider has no authority to access the individual's confidential eligibility information.

Denti-Cal Beneficiary Reimbursements

Beneficiary Reimbursements

In accordance with Welfare and Institutions Code Section 14019.3, a California Medi-Cal Dental Program (Denti-Cal) provider is required to reimburse a Denti-Cal beneficiary who paid for a medically necessary covered

service rendered by the provider during any of the following three time periods: 1) the 90-day period prior to the month of application for Denti-Cal; 2) the period after an application is submitted but prior to the issuance of the beneficiary's Medi-Cal card; and 3) after issuance of the beneficiary's Medi-Cal card for excess co-payments (i.e., co-payments that should not have been charged to the beneficiary).

By law, a Denti-Cal provider must reimburse a beneficiary for a claim if the beneficiary provides proof of eligibility for the time period during which the medically necessary covered service was rendered (and for which the beneficiary paid). Evidence of the reimbursement paid by the provider to the beneficiary should be submitted to the Denti-Cal program as a claim with the appropriate documentation to indicate that Denti-Cal eligibility was recently disclosed. The Department of Health Services (Department) will allow the provider a timeliness override in order to bill Denti-Cal for the repaid services. If the provider does not reimburse the beneficiary, the beneficiary may contact the Department, inform the Department of the provider's refusal to reimburse, and then submit a request for reimbursement directly to the Department. In this case, the Department will contact the provider and request that the provider reimburse the beneficiary. Should the provider refuse to cooperate, the Department will reimburse the beneficiary for valid claims and recoup the payment from the provider. Additional sanctions may be imposed on the provider such as those set forth in Welfare and Institutions Code Section 14019.3.

Verifying Eligibility

Beneficiary eligibility information is immediately available on-line to Denti-Cal providers through the Medi-Cal Automated Eligibility Verification System (AEVS). To access AEVS, providers may call (800) 456-2387 and, if outside California, may call (800) 866-2387. AEVS verifies a beneficiary's eligibility for the current month and/or prior 12 months. This system is updated daily based on information received from the State. AEVS does provide eligibility information for beneficiaries enrolled in a special program; however, eligibility information for the Child Health and Disability Prevention (CHDP) program, the California Children Services (CCS) program or the Genetically Handicapped Persons Program (GHPP) is available on AEVS. Occasionally, eligibility information provided by AEVS may include a telephone number for that beneficiary's plan. Provider offices requiring clarification of the eligibility message should call that number to request specific data concerning the beneficiary's coverage, or contact the Medi-Cal medical fiscal intermediary, EDS, at (800) 541-5555.

It is the provider's responsibility to verify a beneficiary's eligibility, as well as eligibility for Other Coverage, Healthy Families and/or managed care plans for Medi-Cal dental services for each month that treatment is provided. Services performed when the beneficiary was ineligible will be denied. Eligibility verified at the first of the month is valid for the entire month of service; therefore, it is necessary to call only once during the month to verify eligibility for the beneficiary. Use of AEVS does not guarantee that the claim will be paid. All existing conditions – such as Share of Cost (SOC) certification, provider eligibility and the criteria and policies of Denti-Cal – must still be satisfied. Please remember to make a copy of the beneficiary's Medi-Cal Benefits Identification Card, as well as a copy of the beneficiary's valid photo ID (i.e., drivers license, passport or current school ID).

There are several ways for a provider to access AEVS to verify a beneficiary's eligibility. Providers using the BIC may access AEVS in several ways. These include the point-of-service (POS) device, Claims and Eligibility Real-Time System (CERTS), vendor-supplied software, the Medi-Cal web site, and the telephone AEVS. If you would like to request a POS device or software, please call the POS/Internet Help Desk at (800) 541-5555.

Personal Identification Number

In order to access AEVS, a provider must have a special personal identification number, or PIN. The PIN is issued to providers when they enroll in Denti-Cal. It is a private access number that should not be given to anyone else. This number should never be given to beneficiaries to access the eligibility system

themselves or call Denti-Cal with questions. Providers are responsible for any activity that is performed with their PIN. If you forget your PIN or misplace the original correspondence you received when your PIN was initially issued to you, please do not call Denti-Cal to request this information. Send your written request for a new PIN to:

Denti-Cal
California Medi-Cal Dental Program
Provider Enrollment Department
P.O. Box 15609
Sacramento, CA 95852-0609

Eligibility Verification Confirmation Number (EVC)

When providing eligibility information, AEVS will issue a 10-character eligibility verification confirmation number (EVC) as a confirmation of the information given. The alpha characters (letters) that appear in the EVC number should not be confused with other alpha characters that are present in various eligibility messages given by the Medi-Cal Automated Eligibility Verification System. The alpha character that appears in a beneficiary's EVC number does not signify the beneficiary's scope of coverage or represent the other coverage carrier code. The alpha characters used in the EVC number are randomly assigned and will change periodically. They do not signify the beneficiary's scope of coverage or represent the other coverage carrier codes.

The EVC number should be entered in the Comments area of the claim or treatment authorization form (box 34) when it is submitted to Denti-Cal. To avoid having a claim denied for recipient eligibility, the treatment form or claim must be submitted with the same provider number, recipient ID and date of service used for the AEVS inquiry. (It is important to note that the EVC number does not replace the recipient's Medi-Cal ID number or Social Security Number.) For your document to be accepted for processing, the Medi-Cal ID number or Social Security Number as well as the beneficiary's date of birth must be present in areas 2 and 4 on the claim or TAR.

If the recipient has an unmet SOC, no EVC number will be given unless the recipient has other coverage (eligible for services under more than one aid code). For a recipient with other coverage who is eligible for certain services with no SOC and the remaining services with a SOC, the aid code and corresponding eligibility message as well as an EVC number are given in the eligibility message for the non-SOC aid code only. A SOC message will then be given for the SOC aid code. For more information on SOC, please see the area entitled "Share of Cost" in this section.

Internet Access and the Denti-Cal and Medi-Cal Web Sites

The Denti-Cal Web site (www.denti-cal.dhs.ca.gov) and the Medi-Cal Web site (www.medi-cal.ca.gov) are now available for use 24 hours a day, seven days a week. In addition to Internet access, providers will need Microsoft Internet Explorer® or Netscape Navigator®. The latest versions of these browsers and other tools, such as Adobe Acrobat®, may be accessed through the Web sites toolbox link. Both Web sites provide links to other sites with useful and related information.

The Denti-Cal Web site is designed to provide access to Denti-Cal bulletins, the Denti-Cal Provider Manual, regulations, and forms for enrolling in the Medi-Cal Dental Program. Denti-Cal providers also have access to telephone numbers and seminar information.

Using the Medi-Cal Web site to access eligibility or perform SOC transactions requires a networking agreement from the POS/Internet Help Desk. Those providers who have not signed up with the POS Help Desk will hear a message stating they are not signed up to perform transaction services.

Medi-Cal Provider Services allow providers to submit and receive eligibility information, as well as perform Share of Cost transactions. Beneficiary and provider information is protected by electronic security measures. Authentication and Secure Socket Layer (SSL) technology ensure provider security and two-way only encryption of data.

Authentication requires providers to enter a valid provider number and PIN. Your Denti-Cal provider number, (without the use of a hyphen or a space between provider ID and service office) serves as the USER ID number, and

your Denti-Cal six-digit PIN serves as the PASSWORD.

POS/CERTS AUTOMATED ELIGIBILITY VERIFICATION SYSTEM (AEVS)

The dental office can determine a beneficiary's eligibility by using the BIC to access AEVS through the POS device, which is available to qualified providers. The beneficiary's BIC is guided through the POS machine, which provides a read-out of the information contained on the magnetic strip on the card. The POS device can also print out the eligibility information on a tape that can then be placed in the beneficiary's file for future reference. This information may also be obtained through computer software (CERTS) designed especially for office computers.

The information printed from the POS or CERTS will contain the following:

- the first six letters for the patient's name
- the patient's first initial
- the county code
- the patient's aid code
- the EVC number
- share of cost and other coverage information and any limitations or restrictions to the patient's eligibility.

Note: If the meaning of any response given by the AEVS is unclear, please contact the Medi-Cal medical fiscal intermediary, EDS, at (800) 541-5555.

Telephone AEVS

How to Use AEVS

Beneficiary eligibility for Medi-Cal service may also be determined by calling AEVS with a touch-tone phone at (800) 456-AEVS (2387). A provider whose practice is outside of California should call (800) 866-2387.

AEVS Hours of Availability

Telephone AEVS is available between the hours of 2:00 a.m. and midnight, seven days a week. If attempting to access telephone AEVS during non-operational hours, the following message will be received:

> *"The Medi-Cal Automated Eligibility Verification System is available between 2:00 a.m. and midnight. Please call back during these hours of operation. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

In the unlikely event telephone AEVS is unavailable during normal hours of operation, the following message will be received:

> *"The Medi-Cal Automated Eligibility Verification System is currently unavailable. Please call back later. Thank you for calling the Medi-Cal Automated Eligibility Verification System. Good-bye."*

Limitations

To ensure optimal availability of telephone AEVS, providers are limited to a maximum of 10 inquiries for each telephone call. An inquiry is any request sent to the Medi-Cal Host computer. Any combination of inquiries, to *a maximum of 10*, are allowed per telephone call. For example, if verification is requested for a single recipient for the current month and three previous months, that is considered four inquiries. Or, if the Medi-Cal Host states an error has been made, resubmitting the transaction constitutes two inquiries.

Preparation for Calling AEVS

Before accessing telephone AEVS, it is important to have the required information ready to enter when prompted by AEVS. This information includes:

- six-digit provider identification number (PIN);
- the 10-digit recipient's identification number;
- the recipient's date of birth;
- the date of service for which eligibility is needed.

Telephone AEVS allows a specified amount of time following each prompt to enter information using a touch-tone telephone. If there is no response to a prompt within five seconds, AEVS will prompt three more times. If no information is entered after the third reminder, AEVS will terminate the call with the following message:

> *"We're sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or the AEVS Section of your provider manual. If you have any questions concerning AEVS, please contact the POS/Internet Help Desk at 1-800-541-5555. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Goodbye."*

Following receipt of AEVS eligibility information, record the information in the beneficiary's records for future reference in completing claim forms. Be prepared to write down the eligibility information for each inquiry as it is given. AEVS will give an EVC number for each inquiry receiving an eligible response. AEVS will provide the option to repeat eligibility information and the verification code as needed to ensure information is recorded correctly.

Figure 2-18

AEVS Reference Guide

AEVS: 1 (800) 456- AEVS (2387)

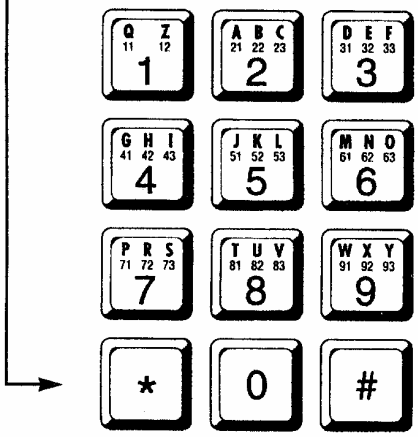
ALPHABETIC CODE LISTING

The alphabetic code listing for AEVS is as follows:

LETTER	2-DIGIT CODE
A	*21
B	*22
C	*23
D	*31
E	*32
F	*33
G	*41
H	*42
I	*43
J	*51
K	*52
L	*53
M	*61

LETTER	2-DIGIT CODE
N	*62
O	*63
P	*71
R	*72
S	*73
T	*81
U	*82
V	*83
W	*91
X	*92
Y	*93
Q	*11
Z	*12

*Press * before entering the two-digit code*



SPECIAL FUNCTION KEYS FOR AEVS

Keys	Purpose
[#]	End data entry in a field; proceed to next field
[*#]	Repeat the menu option
[* *]	Delete the current data entry in a field
[* 99 #]	Return to the main menu

Special Functions for AEVS That Facilitate Use

After you have become accustomed to the system and the prompt messages, you may choose to "bypass" listening to the entire prompt. To use the "bypass" feature, enter the appropriate data after the beginning of each prompt.

There are also special functions that can be performed by using the Star Key (*) on your touch-tone phone which will help you use Telephone AEVS. These functions are :

Repeat Previous Prompt [*#]:

Pressing the star key followed by the pound sign key [*#] will cause AEVS to repeat the previous prompt.

Delete Enter Data [**]:

To delete all entered data in a current field, press the star key twice, then enter the correct data.

For example if you intended to enter "12345" but accidentally keyed "12567," the mistake can be corrected by entering [**] followed by the correct data and the pound sign key (#). The sequence of keystrokes would be:

12567**12345#

By pressing the pound sign key [#], you end the data entry. When AEVS receives the input, it discards all data in the field preceding the double star and takes the data following the double star as the intended input. The final input to AEVS would be 12345.

Return to Main Menu [*99#]:

Pressing the star key, followed by "99," followed by the pound sign key [*99#] will return you to the main menu and you will hear the following:

"To perform an Eligibility Verification, press 1. To perform a share of cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-Only Family Planning program transaction, press 4. To end this call, press 5."

Help Prompt [*4#]:

Pressing the star key followed by "4," followed by the pound sign key [*4#] will cause AEVS to speak the following message:

"Special touch-tone features exist for this application. To repeat the previous prompt, press star pound [#]. To void data entered, press star star [**] and reenter the correct data. To go to the main menu, press star nine nine pound [*99#]. Press star four pound [*4#] to hear this help message any time during your call."*

AEVS Eligibility Messages

When calling AEVS for eligibility information, AEVS will respond with the following message:

"Welcome to the Medi-Cal Automated Eligibility Verification System, also referred to as A-E-V-S. Please enter your provider identification number followed by a pound sign."

Enter your six-digit PIN, followed by the pound-sign key (#). AEVS will respond with the following message:

"Please wait while the requested information is retrieved."

If the PIN cannot be found on the provider master file, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the second try, the call will be terminated with instructions on where to get more information.

If the PIN can be verified by AEVS, you will receive the following prompt:

"If your provider number is _____, press 1 to continue. To perform an eligibility verification, press 1. To perform a share of cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-Only Family Planning program transaction, press 4. To end this call, press 5."

Press "1" to verify eligibility. (Disregard transaction selection 3. It is not applicable to Denti-

Cal providers.) You will then hear the following message:

> *"Please enter your recipient identification number, followed by a pound sign."*

Enter the recipient's 10-character Medi-Cal identification number followed by the pound-sign key (#). If there are any alpha characters in the number, press the star key (*) and number keys that correspond with the location and position of the letter on the telephone key pad. (Please see the Alphabetic Code Listing on page 2-86 of this section.)

If the recipient identification number you entered is invalid, AEVS will prompt you to re-enter the number. If the recipient identifier is entered correctly, you will receive the following message:

> *"Please enter the two-digit month and four-digit year of the recipient's birth date. For example, enter a birth date of June 20, 1972 as `061972'."*

If you are verifying eligibility for a newborn infant billing on the mother's identification number, enter the mother's date of birth. If the recipient birth date you entered is invalid, AEVS will prompt you to re-enter the date. If the date is entered correctly, you will need to enter the date of service for which you need eligibility. AEVS will give you the following instructions:

> *"Please enter the two-digit month, two digits for the day and four digits for the year. For example, enter May 5, 1994 as 05051994."*

When a valid date is entered, AEVS will attempt to access the requested recipient's eligibility information. At this point, you should be prepared to record the information provided by AEVS.

If the recipient's eligibility cannot be verified, you will receive the following message:

> *"No recorded eligibility for _____ (month, year) for recipient _____ (ID #) with a date of birth of _____ (date). To hear this information again, press 1. Otherwise, please press 2."*

If the recipient has an unmet share of cost, you will hear the following message:

> *"This Medi-Cal recipient has a share of cost of ___ dollars. To hear this information again, press 1. Otherwise, press 2."*

(For information on how to perform a share of cost transaction, please see the "Share of Cost" section below.)

If AEVS is successful in retrieving the recipient's eligibility information for the month that you requested, you will receive the following message that will verify the recipient's eligibility by giving you the first six letters of the last name and the first initial (Note: After this message is spoken, please be prepared to record the recipient's eligibility information):

> *"Thank you."*
>
> *"The first six letters of the recipient's name are _____."*
>
> *"The recipient's first initial is __."*
>
> *"The county code is __."*
>
> *"The aid code is __."*
>
> *"The eligibility confirmation number is __."*

Following are examples of messages you may receive when the AEVS provides you with the recipient eligibility information that you requested. A recipient may have more than one eligibility message spoken for each transaction. Be prepared to record each message:

> *"Recipient is Medi-Cal eligible."*
>
> *"Recipient is Medi-Cal eligible for dialysis and related services only, with __ percent obligation."*
>
> *"Recipient is restricted to medical services related to pregnancy and family planning."*
>
> *"The recipient has other health insurance coverage under code _____ (OHC code) _____ (OHC name) _____ (carrier code). Scope of coverage is ____ (scope of coverage [COV] code[s])."*

In addition to letter codes indicating the name of the other health coverage carrier, AEVS messages also provide letter codes that indicate the scope of coverage for the recipient. These codes are:

- D = dental
- I = hospital inpatient
- L = long-term care

M = medical and allied services
O = hospital outpatient
P = prescription drugs
V = vision care

After all eligibility messages are spoken for this transaction, you will receive the following message:

"To hear this information again, press 1. Otherwise, press 2."

Note: If you are unsure of the meaning of any response given by the AEVS, please contact the Medi-Cal medical fiscal intermediary, EDS, at (800) 541-5555.

If you press 2, you will return to the main menu and hear the following message:

"To perform an eligibility verification, press 1. To perform a share of cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a state-only family planning program transaction, press 4. To end this call, press 5."

Share of Cost

Share of Cost is a procedure the State of California Department of Health Services developed to ensure that an individual or family meets a predetermined financial obligation for medical and dental services before receiving Medi-Cal benefits. Prior authorization requirements are not waived for share of cost beneficiaries. The share of cost obligation is incurred each month and, consequently, the amount of obligation may vary from month to month. The dollar amount to be applied to any health care cost incurred during that month is computed in order to meet the share of cost. Health care costs could be dental, medical, pharmaceutical, hospital, etc. Beneficiaries may use non-Medi-Cal covered services in meeting the monthly share of cost obligation.

Providers can determine a beneficiary's share of cost when verifying the beneficiary's eligibility through AEVS or by referring to the beneficiary's Share of Cost Case Summary letter. AEVS will report if a beneficiary has an unmet share of cost before providing an eligibility verification confirmation number (EVC). Providers may collect payment on the date that services are rendered, or they may allow a beneficiary to pay for the services at a later date or through an installment arrangement. Share of Cost obligations are between the beneficiary and the provider and they should be in writing and signed by both parties.

The Medi-Cal Share of Cost obligation can apply to an individual or family as a whole. Family members who are not eligible for Medi-Cal may be included in the beneficiary's share of cost. The health care costs for these ineligible family members can be used to meet the share of cost obligation for family members who are eligible. Ineligible family members who are able to do this are identified by an "IE" or "00" aid code on the beneficiary's share of cost letter.

Natural or adoptive parents (coded as "RR" on their child's share of cost form) may choose to apply their medical expenses towards their own share of cost or towards their child's share of cost. In this instance, parents' expenses can be listed fully towards their own share of cost or applied partially towards their share of cost and any of their children's share of cost. However, the total amount reported for a single medical expense cannot be more than the original bill.

- An example of this situation would be a family that consists of a stepfather, his wife and his wife's separate child. The wife and her husband are listed as eligible recipients on the same share of cost letter with a $100 share of cost. The wife's separate child is listed on a different share of cost letter with a $125 share of cost. The wife is also listed on her child's share of cost letter with an "RR" code in the aid code field.
- The wife has expenses that total $75 and that have not been billed to Medi-Cal. She may do one of the following:
  1. Apply the entire $75 to her own $100 share of cost.
  2. Apply the entire $75 to her own child's $125 share of cost.
  3. Apply any amount less than $75 to her share of cost and the balance of the $75 to her child's share of cost. The total amount reported cannot exceed the original $75.

Providers should submit a share of cost clearance transaction immediately upon receiving payment from the beneficiary. The share of cost clearance transaction can be performed by entering the amount through AEVS. Once this amount has been entered, eligibility can be established for that month for the family members eligible for Medi-Cal.

If the beneficiary's share of cost obligation has been met, providers are entitled to bill Denti-Cal for those services that have been partially paid for by the beneficiary and all other services not paid for by the beneficiary. However, total payments from the beneficiary and Denti-Cal will not exceed the Schedule of Maximum Allowances (SMA).

Performing a Share of Cost Transaction Using AEVS

Providers should update a share of cost transaction the same day services are provided to the beneficiary. When performing a share of cost transaction using AEVS, each procedure code and date the procedure was performed must be entered. The share of cost transaction must match the date the appliance was sent to the laboratory for final fabrication.

Providers are required to submit claims to Denti-Cal for all services that have been performed for the beneficiary, including procedures paid by the beneficiary, due to share of cost obligation. Those procedures partially paid by the beneficiary, due to share of cost, or not paid by the beneficiary will be eligible for possible reimbursement by Denti-Cal. Please remember to use the correct date and fee collected for every procedure code entered. The date of service should be entered using two (2) digits for the month, two (2) digits for the day, and four (4) digits for the year, e.g., enter May 1, 2006 as 05012006. Note: If the date of service is re-entered, it is considered to be an additional inquiry. This will count against the ten (10) allowable inquiries.

Once the beneficiary's full share of cost amount has been entered through AEVS, the share of cost will be considered certified (obligation met). Once the beneficiary's share of cost has been certified, a share of cost transaction reversal cannot be performed.

Using a touch-tone telephone, dial (800) 456-AEVS (2387). A provider whose practice is outside of California should call (800) 866-2387. AEVS will respond with the following message:

> *"Welcome to the Medi-Cal Automated Eligibility Verification System, also referred to as A-E-V-S.*
>
> *Please enter your provider identification number followed by a pound sign."*

Enter your six-digit PIN followed by the pound sign key (#). AEVS will respond with the following message:

> *"Please wait while the requested information is retrieved."*

If the PIN cannot be found on the provider master file, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the second try, the call will be terminated with instructions on where to get more information.

If the PIN can be verified by AEVS, you will receive the following prompt:

> *"To perform an eligibility verification, press 1. To perform a share of cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a state-only family planning program transaction, press 4. To end this call, press 5."*

Press 2 to clear a share of cost liability or to reverse a previous clearance. You will then hear the following message:

> *"To perform an update, press 1. To perform a reversal, press 2."*

If you wish to clear a share of cost liability, press 1. If you wish to reverse a previously cleared share of cost liability, press 2. After you make your selection, you will receive the following message:

> *"Please enter your recipient identification number, followed by a pound sign."*

Enter the recipient's 10-character Medi-Cal identification number followed by the pound sign key (#). If there are any alpha characters in the number, press the star key (*) and number keys that correspond with the location and position of the letter on the telephone key pad

(please see the Alphabetic Code Listing on page 2-86 of this section).

If the recipient identification number you entered is invalid, AEVS will prompt you to reenter the number. If the recipient identifier is entered correctly, you will receive the following message:

> *"Please enter the two-digit month and four-digit year of the recipient's birth date. For example, enter a birth date of June 20, 1972 as '061972'."*

If you are performing this transaction for services rendered to a newborn infant billing on the mother's identification number, enter the mother's date of birth.

If the recipient birth date you entered is invalid, the AEVS will prompt you to re-enter the date. If the date is entered correctly, you will receive the following message:

> *"Please enter the date of service in the format of two digits for the month, two digits for the day, and four digits for the year. For example, enter March 5, 1994 as '03051994'."*

If the date of service you entered is invalid, the AEVS will prompt you to re-enter the date. Note: If you have to re-enter the date of service, this is considered to be an additional inquiry and will count against the ten inquiries you are allowed per call.

If the date is entered correctly, you will receive the following message:

> *"Please enter a five-character or 11-character procedure code followed by a pound sign."*

Enter the Denti-Cal three-, four-, or five-digit procedure code followed by the pound-sign key (#). If the procedure code that you entered is invalid, the AEVS will prompt you to re-enter the code. If the code is entered correctly, you will receive the following message:

> *"The procedure code entered was ____ (procedure code). Is this entry correct? Enter 1 for yes or 2 for no."*

If you press 1, you will hear the following message:

> *"Please enter the total billed amount in the format of dollars followed by a star and cents followed by a pound sign."*

For example, to enter a total billed amount of $20.50, enter 20*50#. If the amount you entered is invalid, the AEVS will prompt you to re-enter the amount. If the amount is entered correctly, you will receive the following message:

> *"The billed amount entered was ____ (amount). Is this entry correct? Enter 1 for yes or 2 for no."*

If you press 1, you will hear the following message:

> *"Please enter the case number followed by a pound sign. Enter only the pound sign if you wish to bypass the case number."*

Enter a pound sign (#) if the recipient does not have multiple share of cost cases. If the recipient has multiple cases, follow the steps listed under "Multiple Cases" below.

After you press the pound-sign key (#) for a recipient without multiple cases, you will hear the following message if the recipient has additional liability:

> *"The amount deducted was _____ (amount). The amount of share of cost remaining is _____ (amount)."*

After you press the pound sign key (#) for a recipient without multiple cases, you will hear the following message if the recipient's share of cost is certified (no share of cost liability remaining):

> *"The first six letters of the recipient's name are _____. The recipient's first initial is _.*
>
> *The county code is __. The aid code is __.*
>
> *The amount deducted was _____. Share of Cost certified. The eligibility confirmation number is ___."*

You will then hear the messages telling you what kind of eligibility and/or restrictions the recipient has. For example:

> *"Recipient is Medi-Cal eligible."*
>
> *"Recipient is Medi-Cal eligible for dialysis and related services only, with __ percent obligation."*

"Recipient is restricted to medical services related to mental health care."

Multiple Cases

If the recipient has multiple cases, enter the case number you wish to hear and press the pound-sign key (#). The recipient will have a letter listing all case numbers. If you do not enter a case number and there is more than one case number associated with the recipient, you will hear the following message:

"Recipient is in multiple cases. The recipient has the following share of cost case numbers: Case number ___ currently has a share of cost amount of _____. Case number ___ currently has a share of cost amount of _____. (You will hear one to four case numbers associated with the recipient.) Please enter the case number followed by a pound sign."

If the recipient has more than four case numbers, you will also hear the following:

"The recipient also has additional share of cost case numbers not mentioned in this transaction."

If you press 1, you will hear the following message:

"The applied amount entered was _____. Is this entry correct? Enter 1 for yes or 2 for no."

If you press 1, you will hear the following message if you requested a share of cost reversal:

"Amount added was _____. Amount of share of cost remaining is _____."

If you requested a share of cost clearance for a recipient whose county has not phased to plastic Benefits Identification Cards, you will hear the following message:

"The share of cost clearance system is not operative in the recipient's county for the month requested. "

Note: If you are unsure as to the meaning of any response given by the AEVS, please contact the Medi-Cal medical fiscal intermediary, EDS, at (800) 541-5555.

Figure 2-7

Sample Claim Demonstrating SOC Billing

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone 800-423-0507

CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)	2. PATIENT SOC. SEC. NO.	3. SEX (M / F)	4. PATIENT BIRTHDATE (MO / DAY / YR)	5. PATIENT MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	x	mm / dd / yyyy	9999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
address	
CITY, STATE — address — ZIP CODE	8. REFERRING PROVIDER NUMBER

9. RADIOGRAPHS ATTACHED?	YES	11. ACCIDENT/INJURY?	YES	13. OTHER DENTAL COVERAGE?	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION?	YES
HOW MANY? 3		EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

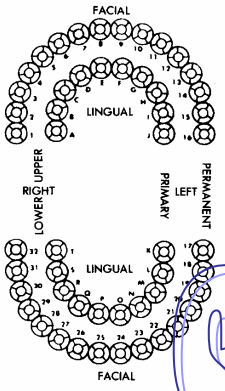
19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. MEDI-CAL PROVIDER NUMBER
Adams, James DDS	Gxxxxx-01
21. MAILING ADDRESS — 30 Main Street	TELEPHONE NUMBER (XXX) XXX-XXXX
CITY, STATE — Anytown, CA	ZIP CODE XXXXX-XXXX

PLEASE AFFIX P.O.E. LABELS IN THIS BOX IN CHRONOLOGICAL ORDER

P.O.E.

22. PLACE OF SERVICE: OFFICE **X** | HOME | CLINIC | SNF | ICF | HOSPITAL IN-PATIENT | HOSPITAL OUT-PATIENT | OTHER (PLEASE SPECIFY)

25. IDENTIFY MISSING TEETH WITH "X"



24. **EXAMINATION AND TREATMENT** - LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32

26. TOOTH NO. OR LETTER A-K-O-T	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY.	31. PROCEDURE NUMBER	32. FEE	33. TREATING MEDI-CAL PROVIDER NO.
		1 exam	9/10/01		010	25.00	D12345
		2 4 bw x-rays	9/10/01		117	20.00	
		3 prophy	9/10/01		050	45.00	
3	O	4 amalgam	9/13/01		611	55.00	D12345
4	MO	5 amalgam	9/13/01		612	65.00	D12345
5	DO	6 amalgam	9/13/01		612	65.00	D12345
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	275.00
36. PATIENT SHARE-OF-COST AMOUNT	80.00
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	09/13/01

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X *James Adams, DDS* (SIGNATURE) *9/13/01* (DATE)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your Claim an X-Ray Envelope containing your X-Rays **MUST** be attached to this form. The X-Ray Envelopes (DC 014A and DC 014C) are available free of charge from the Denti-Cal Forms Supplier.

[redacted]

DC-017A (R4/96)

DENTI-CAL COPY

Aid Codes The following aid codes identify the types of services for which different Medi-Cal/CMSP/CCS/GHPP beneficiaries are eligible.

Aid Code	Benefits	SOC	Program/Description
0A	Full	No	Refugee Cash Assistance (FF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0M	Full	No	Accelerated Enrollment (AE) of temporary, full scope, no Share of Cost (SOC) Medi-Cal only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, **found in need of treatment, and who have no creditable health insurance coverage. Eligibility is limited to two months because the individual did not enroll for on-going Medi-Cal.**
0N	Full	No	AE of temporary, full-scope, no SOC Medi-Cal coverage only for females 65 years of age and younger, who are diagnosed with breast and/or cervical cancer, **found in need of treatment, and who have no creditable health insurance coverage. No time limit.**
0P	Full	No	Full scope, no SOC Medi-Cal only for females 65 years of age and younger who are diagnosed with breast and/or cervical cancer and found in need of treatment; who have no creditable health insurance coverage **and who are eligible for the duration of treatment**.
0R	Restricted Services	No	Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for all males and females (regardless of age or immigration status). These individuals must have high cost other health coverage cost-sharing insurance (over $750/year), have a diagnosis of breast (payment limited to 18 months) and/or cervical (payment limited to 24 months) cancer, and are found in need of treatment.
0T	Restricted Services	No	Provides payment of 18 months of breast and 24 months of cervical cancer treatment services for all aged males and females **who are not eligible under aid codes 0P, 0R, or 0U**, regardless of citizenship, that are diagnosed with breast and/or cervical cancer and found in need of treatment. This aid code does not contain anyone with other creditable health insurance, **regardless of the amount of coinsurance. Does not cover individuals with expensive creditable insurance or anyone with unsatisfactory immigration status.**

Aid Code	Benefits	SOC	Program/Description
0U	Restricted Services	No	Provides services only for females with unsatisfactory immigration status, who are 65 years of age or younger, diagnosed with breast and/or cervical cancer and are found in need of treatment. These individuals are eligible for federal Breast and Cervical Cancer Treatment Program (BCCTP) for emergency services for the duration of the individual's treatment. State-only breast (payment limited to 18 months) and cervical (payment limited to 24 months) cancer services, pregnancy-related services and LTC services. Does not cover individuals with other creditable health insurance.
0V	Limited	No	Provides Emergency, Long Term Care, and Pregnancy-related services, with no share of cost, to individuals no longer eligible for the Breast and Cervical Cancer Treatment Program.
01	Full	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.
02	Full	Y/N	Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.
03	Full	No	Adoption Assistance Program (AAP) (FFP). A cash grant program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.
04	Full	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC) (non-FFP). Covers cash grant children receiving Medi-Cal by virtue of eligibility to AAP/AAC benefits.
07	Restricted to emergency services	No	Asset Waiver Program. Infant – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides emergency services only for infants up to age 1 year and continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is between 185 percent and 200 percent of the Federal poverty level (State-only program).
08	Full	No	Entrant Cash Assistance (ECA) (FFP). Provides ECA benefits to Cuban/Haitian entrants, including unaccompanied children who are eligible, during their first eight months in the United States. (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the eighth-month limitation provision.

Aid Code	Benefits	SOC	Program/Description
1E	Full	No	Craig v. Bonta Continued Eligibility for the Aged. Aid code 1E covers former SSI beneficiaries who are aged (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
1H	Full	No	Federal Poverty Level – Aged (FPL-Aged). Provides full-scope (no Share of Cost) Medi-Cal to qualified aged individuals/couples.
1U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Aged (Restricted FPL-Aged). Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified aged individuals/ couples who do not have satisfactory immigration status.
1X	Full	No	Multipurpose Senior Services Program (MSSP) waiver provides full scope benefits, MSSP transitional and non-transitional services, with no share of cost and with federal financial participation.
1Y	Full	Yes	Multipurpose Senior Services Program (MSSP) waiver provides full scope benefits, MSSP transitional and non-transitional services, with a share of cost and with federal financial participation.
10	Full	No	SSI/SSP Aid to the Aged (FFP). A cash assistance program administered by the SSA which pays a cash grant to needy persons 65 years of age or older.
13	Full	Y/N	Aid to the Aged – LTC (FFP). Covers persons 65 years of age or older who are medically needy and in LTC status.
14	Full	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.
16	Full	No	Aid to the Aged – Pickle Eligibles (FFP). Covers persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions in the Lynch v. Rank lawsuit.
17	Full	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required.

Aid Code	Benefits	SOC	Program/Description
18	Full	No	Aid to the Aged – IHSS (FFP). Covers aged IHSS cash recipients, 65 years of age or older, who are not eligible for SSI/SSP cash benefits.
2A	Full	No	Abandoned Baby Program. Provides full-scope benefits to children up to three months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.
2E	Full	No	Craig v. Bonta Continued Eligibility for the Blind. Aid code 2E covers former SSI beneficiaries who are blind (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
20	Full	No	SSI/SSP Aid to the Blind (FFP). A cash assistance program, administered by the SSA, which pays a cash grant to needy blind persons of any age.
23	Full	Y/N	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.
24	Full	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.
26	Full	No	Aid to the Blind – Pickle Eligibles (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of the Lynch v. Rank lawsuit. (See aid code 16 for definition of Pickle eligibles.)
27	Full	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.
28	Full	No	Aid to Blind – IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See aid code 18 for definition of eligibility for IHSS.)
3A	Full	No	Safety Net - All Other Families, CalWORKs, Timed-Out, Child-Only Case. This program provides for continued cash and Denti-Cal coverage of children whose parents have been discontinued from cash aid and removed from the assistance unit (AU) due to reaching the CalWORKs 60-month time limit without needing a time extender exception.

Aid Code	Benefits	SOC	Program/Description
3C	Full	No	Safety Net - Two-Parent, CalWORKs Timed-Out, Child-Only Case. This program provides for continued cash and Denti-Cal coverage of children whose parents have been discontinued from cash aid and removed from the AU due to reaching the CalWORKs 60-month time limit without meeting a time extender extension.
3E	Full	No	CalWORKs LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.
3G	Full	No	AFDC-FG (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent, who does not meet all federal requirements, but State rules require the individual(s) be aided. This population is the same as aid code 32, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3H	Full	No	AFDC-FU (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home. This population is the same as aid code 33, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3L	Full	No	CalWORKs LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.
3M	Full	No	CalWORKs LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.
3N	Full	No	AFDC – Mandatory Coverage Group Section 1931(b) (FFP). Section 1931 requires Medi-Cal be provided to low-income families who meet the requirements of the Aid to Families with Dependent Children (AFDC) State Plan in effect July 16, 1996.

Aid Code	Benefits	SOC	Program/Description
3P	Full	No	AFDC Unemployed Parent (FFP cash) – Aid to families in which a child is deprived because of the unemployment of a parent living in the home and the unemployed parent meets all federal AFDC eligibility requirements. This population is the same as aid code 35, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/Califor-nia Work Pays Demonstration Project.
3R	Full	No	Aid to Families with Dependent Children (AFDC) – Family Group (FFP) in which the child/children is/are deprived because of the absence, incapacity or death of either parent. This population is the same as aid code 30, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
3T	Restricted to pregnancy and emergency services	No	Initial Transitional Medi-Cal (TMC) (FFP). Provides six months of emergency and pregnancy-related initial TMC benefits (no SOC) for aliens who do not have satisfactory immigration status (SIS) and have been discontinued from Section 1931(b) due to increased earnings from employment.
3U	Full	No	CalWORKs LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.
3V	Restricted to pregnancy and emergency services	No	Section 1931(b) (FFP). Provides emergency and pregnancy-related benefits (no SOC) for aliens without SIS who meet the income, resources and deprivation requirements of the AFDC State Plan in effect July 16, 1996.
3W	Full	No	Temporary Assistance for Needy Families (TANF) -Timed out, mixed case. Recipients who reach the TANF 60-month time limit, remain eligible for CalWORKs and the family includes at least one non-federally eligible recipient.
30	Full	No	AFDC-FG (FFP). Provides aid to families with dependent children in a family group in which the child/children is/are deprived because of the absence, incapacity or death of either parent.
32	Full	No	TANF-Timed out. Recipients who have reached their TANF 60-month time limit and remain eligible for CalWORKs.
33	Full	No	AFDC – Unemployed Parent (State-only program) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home.

Aid Code	Benefits	SOC	Program/Description
34	Full	No	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.
35	Full	No	AFDC-U (FFP cash). Provides aid to families in which a child is deprived because of unemployment of a parent living in the home, and the unemployed parent meets all federal AFDC eligibility requirements.
36	Full	No	Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs were disregarded.
37	Full	Yes	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.
38	Full	No	Continuing Medi-Cal Eligibility (FFP). Edwards v. Kizer court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for Medi-Cal only has been determined and an appropriate *Notice of Action* sent.
39	Full	No	Initial Transitional Medi-Cal (TMC) – Six Months Continuing Eligibility (FFP). Provides coverage to certain clients subsequent to AFDC cash grant discontinuance due to increased earnings, increased hours of employment or loss of the $30 and 1/3 disregard.
4A	Full	No	Adoption Assistance Program (AAP). Program for AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s).
4C	Full	No	AFDC-FC Voluntarily Placed (Fed) (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been voluntarily placed in foster care.
4F	Full	No	Kinship Guardianship Assistance Payment (Kin-GAP). Federal program for children in relative placement receiving cash assistance.
4G	Full	No	Kin-GAP. State-only program for children in relative placement receiving cash assistance.
4K	Full	No	Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.

Aid Code	Benefits	SOC	Program/Description
4M	Full	No	Former Foster Care Children (FFCC) 18 through 20 years of age. Provides full-scope Medi-Cal benefits to former foster care children who were receiving benefits on their 18th birthday in aid codes 40, 42, 45, 4C and 5K and who are under 21 years of age.
4P	None	No	CalWORKs Family Reunification – ALL FAMILIES, provides for the continuance of CalWORKs services to all families except two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.
4R	None	No	CalWORKs FAMILY REUNIFICATION – TWO PARENT, provides for the continuation of CalWORKs services to two-parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.
40	Full	No	AFDC-FC/Non-Fed (State FC). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.
42	Full	No	AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.
44	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant (FFP) United States Citizen/U.S. National and aliens with satisfactory immigration status including lawful Permanent Resident Aliens/Amnesty Aliens and PRUCOL Aliens. Provides family planning, pregnancy-related and postpartum services for any female if family income is at or below 200 percent of the federal poverty level.
45	Full	No	Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC.
47	Full	No	Income Disregard Program (FFP). Infant – United States Citizen, Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal benefits to infants up to 1 year old and continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant – Covers aliens who do not have lawful permanent resident, PRUCOL, or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal. Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level. Routine prenatal care is non-FFP. Labor, delivery and emergency prenatal care are FFP.

Aid Code	Benefits	SOC	Program/Description
49	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnancy – Amnesty Alien. Provides family planning, pregnancy-related and postpartum services to any age female with income at or below 200 percent of the federal poverty level.
5F	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers pregnant alien women who do not have lawful permanent resident, PRUCOL or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal.
5G	Restricted to pregnancy and emergency services	No	Medi-Cal eligible for emergency services with no Share of Cost.
5H	Restricted to pregnancy and emergency services	No	Medi-Cal eligible for emergency services with no share of cost.
5J	Restricted Services	No	Beneficiaries, whose linkage has to be redetermined under Senate Bill 87 (SB 87) requirements, are receiving restricted services due to unsatisfactory immigration status, with no SOC, and whose potential new linkage is disability.
5K	Full	No	Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.
5M	Restricted to pregnancy and emergency services	No	Medi-Cal eligible for emergency services with no share of cost.
5N	Restricted to pregnancy and emergency services	Yes	Medi-Cal eligible for emergency services with a share of cost of _____ dollars.
5R	Restricted Services	Yes	Beneficiaries, whose linkage has to be re-determined under SB 87 requirements, are receiving restricted services with a SOC, and whose potential new linkage is disability.
5T	Restricted to pregnancy and emergency services	No	Continuing TMC (FFP). Provides an additional six months of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 3T recipients.
5W	Restricted to pregnancy and emergency services	No	Four Month Continuing (FFP). Provides four months of emergency and pregnancy-related benefits (no SOC) for aliens without SIS who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.

Aid Code	Benefits	SOC	Program/Description
5X	Full	No	Second Year Transitional Medi-Cal (TMC). Provides a second year of full-scope (no SOC) TMC benefits for citizens and qualified aliens age 19 and older who have received six months of additional full-scope TMC benefits under aid code 59 and who continue to meet the requirements of additional TMC. (State-only program.)
5Y	Restricted to pregnancy and emergency services	No	Second Year TMC (state only). Provides a second year of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 5T recipients 19 years of age or older.
50	Restricted to CMSP emergency services only	Y/N	CMSP. MI – Restricted. Covers persons who have undetermined immigration status.
53	Restricted to LTC services only	Y/N	Medically Indigent – LTC (Non-FFP). Covers persons age 21 or older and under 65 years of age who are residing in a Nursing Facility Level A or B and meet all other eligibility requirements of medically indigent, with or without SOC.
54	Full	No	Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the increased collection of child/spousal support payments but eligible for Medi-Cal only.
55	Restricted to pregnancy and emergency services	No	Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color Of Law (PRUCOL). LTC services: State-only funds; emergency and pregnancy-related services: State and federal funds. Recipients will remain in this aid code even if they leave LTC.
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers aliens who do not have lawful permanent resident, PRUCOL or amnesty status (including undocumented aliens), but who are otherwise eligible for Medi-Cal.
59	Full	No	Additional TMC – Additional Six Months Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the expiration of the $30 plus 1/3 disregard, increased earnings or hours of employment, but eligible for Medi-Cal only, may receive this extension of TMC.
6A	Full	No	Disabled Adult Child(ren) (DAC)/Blindness (FFP).
6C	Full	No	Disabled Adult Child(ren) (DAC)/Disabled (FFP).

Aid Code	Benefits	SOC	Program/Description
6E	Full	No	Craig v. Bonta Continued Eligibility for the Disabled. Aid code 6E covers former SSI beneficiaries who are disabled (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.
6G	Full	No	250 Percent Program Working Disabled. Provides full-scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.
6H	Full	No	Federal Poverty Level – Disabled (FPL-Disabled) Provides full-scope (no Share of Cost) Medi-Cal to qualified disabled individuals/couples.
6J	Full	No	Senate Bill (SB) 87 Pending Disability Program. Provides full-scope, no Share of Cost benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and the client claims disability. Medi-Cal coverage continues uninterrupted during the determination period.
6N	Full	No	Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)/No Longer Disabled Recipients (FFP). Former SSI disabled recipients (adults and children not in aid code 6R) who are appealing their cessation of SSI disability.
6P	Full	No	PRWORA/No Longer Disabled Children (FFP). Covers children under age 18 who lost SSI cash benefits on or after July 1, 1997, due to PRWORA of 1996, which provides a stricter definition of disability for children.
6R	Full	Yes	Senate Bill (SB) 87 Pending Disability Program. Provides full-scope, Share of Cost benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and the client claims disability. Medi-Cal coverage continues uninterrupted during the determination period.
6U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Disabled (Restricted FPL-Disabled) Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified disabled individuals/couples who do not have satisfactory immigration status.
6V	Full	No	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.
6W	Full	Yes	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.

Aid Code	Benefits	SOC	Program/Description
6X	Full	No	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.
6Y	Full	Yes	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.
60	Full	No	SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.
63	Full	Y/N	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.
64	Full	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.
65	Full	Y/N	Aid to the Disabled Substantial Gainful Activity/Aged, Blind, Disabled – Medically Needy IHSS (non-FFP). Covers persons who (a) were once determined to be disabled in accordance with the provisions of the SSI/SSP program and were eligible for SSI/ SSP but became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations. They must also continue to suffer from the physical or mental impairment that was the basis of the disability determination or (b) are aged, blind or disabled medically needy and have the costs of IHSS deducted from their monthly income.
66	Full	No	Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v. Rank lawsuit. No age limit for this aid code.
67	Full	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.
68	Full	No	Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See aid codes 18 and 65 for definition of eligibility for IHSS).
69	Restricted to emergency services	No	Income Disregard Program. Infant (FFP) – Undocumented/Non-immigrant Alien (but otherwise eligible). Provides emergency services only for infants under 1 year of age and beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the Federal poverty level.

Aid Code	Benefits	SOC	Program/Description
7A	Full	No	100 Percent Program. Child (FFP) – United States Citizen, Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
7C	Restricted to pregnancy and emergency services	No	100 Percent Program. Child – Undocumented/Nonimmigrant Status/[IRCA Amnesty Alien (Not ABD or Under 18)]. Covers emergency and pregnancy-related services to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
7F	Valid for pregnancy verification office visit	No	Presumptive Eligibility (PE) – Pregnancy Verification (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.
7G	Valid only for ambulatory prenatal care services	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care Services (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive.
7H	Valid only for TB-related outpatient services	No	Medi-Cal Tuberculosis (TB) Program. Covers individuals who are TB-infected for TB-related outpatient services only.
7J	Full	No	Continuous Eligibility for Children (CEC) Program. Provides full-scope benefits to children up to 19 years of age who would otherwise move to a SOC (Share of Cost).
7K	Restricted to pregnancy and emergency services	No	Continuous Eligibility for Children (CEC) Program. Provides emergency and pregnancy-related benefits (no SOC) to children up to 19 years of age who would otherwise move to a SOC.
7M	Valid for Minor Consent services	Y/N	Minor Consent Program (Non-FFP). Covers minors aged 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning.
7N	Valid for Minor Consent services	No	Minor Consent Program (FFP). Covers pregnant female minors under age 21. Limited to services related to pregnancy and family planning.

Aid Code	Benefits	SOC	Program/Description
7P	Valid for Minor Consent services	Y/N	Minor Consent Program (Non-FFP). Covers minors age 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning and outpatient mental health treatment.
7R	Valid for Minor Consent services	Y/N	Minor Consent Program (FFP). Covers minors under age 12. Limited to services related to family planning and sexual assault.
7T	Full	No	Free National School Lunch Program (NSLP) Express Enrollment. Children determined by their school, designated as an express enrollment entity, as eligible for express enrollment.
7X	Full	No	Two months of Healthy Families Program (HFP) Bridge. Provides two calendar months of health care benefits with no SOC to Medi-Cal parents, caretaker relatives, legal guardians, and children who appear to qualify for the Healthy Family Program.
7Y	Full	No	HF to Medi-Cal Bridge (HFP) provides two additional calendar months of HF to adults and children who at the annual review are ineligible for HF and appear to qualify for Medi-Cal.
70	Restricted to pregnancy-related services	No	Asset Waiver Program (Pregnant). United States Citizen, Permanent Resident Alien/PRUCOL Alien or Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides family planning, pregnancy-related, and postpartum services under the state-only funded expansion of the Medi-Cal program for a pregnant woman having income between 185 percent and 200 percent of the federal poverty level (State-Only Program).
71	Restricted to dialysis and supplemental dialysis-related services	Y/N	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP) (Non-FFP). Covers persons of any age who are eligible only for dialysis and related services.
72	Full	No	133 Percent Program. Child-United States Citizen, Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
73	Restricted to parenteral hyperalimentation-related expenses	Y/N	Medi-Cal TPN Only Program/Medi-Cal TPN Supplement Program (Non-FFP). Covers persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.

Aid Code	Benefits	SOC	Program/Description
74	Restricted to emergency services	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
75	Restricted to pregnancy-related services	No	Asset Waiver Program (Pregnant). Provides family planning, pregnancy-related, and postpartum services for amnesty aliens under the state-only funded expansion of the Medi-Cal program for a pregnant woman having income between 185 percent and 200 percent of the federal poverty level (State-Only Program).
76	Restricted to 60-day postpartum services	No	60-Day Postpartum Program (FFP). Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.
79	Full	No	Asset Waiver Program (Infant). Provides full Medi-Cal benefits to infants up to 1 year, and beyond 1 year when inpatient status, which began before first birthday, continues and family income is between 185 percent and 200 percent of the federal poverty level (State-Only Program).
8E	Full	No	Children under the age of 19, apparently eligible for any no-cost Medi-Cal program, will receive immediate, temporary, fee-for-service, full-scope, no-cost Medi-Cal benefits.
8F	CMSP services only (companion aid code)	Y/N	County Medical Services Program (CMSP) Companion Aid Code. Covers persons eligible for certain benefits under the Medi-Cal Program and other benefits under CMSP. 8F is used in conjunction with Medi-Cal aid codes 52, 53 and 57 to facilitate the payment of claims for covered benefits. 8F will appear as a special aid code and will entitle the eligible client to full-scope CMSP coverage for those services not covered by Medi-Cal.
8G	Full	No	Qualified Severely Impaired Working Individual Program Aid Code. Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.
8H	Family PACT (SOFP services only). No Medi-Cal	N/A	Family PACT (also known as SOFP – State Only Family Planning). Comprehensive family planning services for low income residents of California with no other source of health care coverage.

Aid Code	Benefits	SOC	Program/Description
8N	Restricted to emergency services	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8P	Full	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides full-scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.
8R	Full	No	100 Percent Program. Child (FFP) – United States Citizen (with excess property), Lawful Permanent Resident/ PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full-scope benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
8T	Restricted to pregnancy and emergency services	No	100 Percent Program. Child – Undocumented/Nonimmigrant Status/(IRCA Amnesty Alien [with excess property]). Covers emergency and pregnancy-related services only to otherwise eligible children ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
8W	Full	No	Child Health Disability Program (CHDP) Gateway Medi-Cal – Aid Code 8W provides for the pre-enrollment of children into the Medi-Cal program which will provide temporary, no share of cost (SOC), full-scope Denti-Cal benefits. Federal Financial Participation (FFP) for these benefits is available through Title XIX of the Social Security Act.
8X	Full	No	CHDP Gateway Healthy Families – Aid Code 8X provides pre-enrollment of children into the Medi-Cal program. Provides temporary, full-scope Denti-Cal benefits with no SOC until eligibility for the Healthy Families program can be determined. Federal Financial Participation (FFP) for these benefits is available through Title XXI of the Social Security Act.
8Y	CHDP Only	No	CHDP – Aid Code 8Y provides eligibility to the CHDP ONLY program for children who are known to MEDS as not having satisfactory immigration status. There is no Federal Financial Participation for these benefits. This aid code is state funded only.

Aid Code	Benefits	SOC	Program/Description
80	Restricted to Medicare expenses	No	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind, or disabled individuals.
81	Full	Y/N	MI-Adults Aid Paid Pending (Non-FFP). Aid Paid Pending for persons over 21 but under 65, with or without SOC.
82	Full	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
83	Full	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.
84	CMSP services only (no Medi-Cal)	No	CMSP, MI-A (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years who meet the eligibility requirements of medically indigent.
85	CMSP services only (no Medi-Cal)	Yes	CMSP, MI-A (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years, who meet the eligibility requirements of medically indigent.
86	Full	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent.
87	Full	Yes	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
88	CMSP services only (no Medi-Cal)	No	CMSP, MI-A/Disability Pending (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years who meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.
89	CMSP services only (no Medi-Cal)	Yes	CMSP, MI-A/Disability Pending (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years who meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.

Aid Code	Benefits	SOC	Program/Description
9A	BCEDP only	No	The Breast Cancer Early Detection Program (BCEDP) recipient identifier. BCEDP offers benefits to uninsured and underinsured women, 40 years and older, whose household income is at or below 200 percent of the federal poverty level. BCEDP offers reimbursement for screening, diagnostic and case management services. Please note: BCEDP and Medi-Cal are separate programs, but BCEDP is using the Medi-Cal billing process (with few exceptions).
9H	HF services only (no Medi-Cal)	No	The Healthy Families (HF) Program provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 200 percent of the federal poverty level. HF covers medical, dental and vision services to enrolled children.
9J	GHPP	No	Genetically Handicapped Person's Program (GHPP)-eligible. Eligible for GHPP benefits and case management.
9K	CCS	No	California Children's Services (CCS)-eligible. Eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).
9M	CCS Medical Therapy Program only	No	Eligible for CCS Medical Therapy Program services only.
9N	CCS Case Management	No	Medi-Cal recipient with CCS-eligible medical condition. Eligible for CCS case management of Medi-Cal benefits.
9R	CCS	No	CCS-eligible Healthy Families Child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).
9T	Full	No	HF adults linked by a child who is eligible for no Share of Cost Medi-Cal or HF.

Special Indicators: These indicators, which appear in the aid code portion of the county ID number, help Medi-Cal identify the following:

IE – Ineligible: A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

RR – Responsible Relative: An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

Other Coverage

The California Medi-Cal Dental Program follows the regulations in Title 22, California Code of Regulations (CCR), which require full utilization of benefits from all other carriers first. This means Denti-Cal is considered the secondary carrier and can only pay up to the maximum amount allowed for covered benefits. Denti-Cal will make payment only if the primary carrier pays less than the maximum Denti-Cal allowance.

After billing the other coverage carrier, providers should submit a claim to Denti-Cal along with the Explanation of Benefits/Remittance Advice (EOB/RA) or Proof of Denial letter and fee schedule from the other insurance carrier. Denti-Cal will not accept "no other dental coverage" written on the claim, Notice of Authorization for payment, Resubmission Turnaround Document or Claim Inquiry Form. Denti-Cal will apply the coinsurance or deductible to each service in the individual amounts indicated on the EOB/RA and fee schedule; if the other coverage carrier has applied the coinsurance/deductible amount to the claim as a whole, Denti-Cal will distribute the amount equally among all services listed on the claim when calculating payment for covered services. Denti-Cal will pay the difference between the amount the other coverage carrier paid for the service plus the appropriate coinsurance/deductible amount applied to that service, and the Denti-Cal allowed amount for the service.

Prepaid Health Plan (PHP)/Health Maintenance Organization (HMO)

When a Medi-Cal beneficiary has other health coverage that is a PHP or HMO, he or she must use the plan facilities for regular dental care. Providers should also bill the appropriate carrier for out-of-area services or emergency treatment that is covered by a beneficiary's PHP or HMO. Denti-Cal will not pay claims for PHP/HMO-covered dental services provided to beneficiaries with the following other health coverage codes:

OHC	Health Coverage Type
9	Healthy Families
F	Medicare HMO
K	Kaiser
C	CHAMPUS
P	PHP/HMO
V	Fee-For-Service Carriers
A	Pay and Chase
L	Dental Only
N	No Other Coverage

Providers should note that even though the other health coverage code indicates a PHP/HMO, the dental carrier may not be a PHP or HMO. For Denti-Cal to correctly process claims submitted for payment, a Remittance Advice/Explanation of Benefits (RA/EOB), fee schedule or denial of service letter must accompany the claim to verify that the other coverage carrier is a PHP/HMO. Providers who are billing Denti-Cal for services not included in the beneficiary's PHP/HMO plan must submit an RA/EOB, fee schedule or denial letter showing that the PHP/HMO was billed first.

AEVS Other Coverage Codes and Messages

Providers should pay close attention to the messages they receive when verifying eligibility for their Denti-Cal beneficiaries. In addition to the other coverage carrier codes, the Medi-Cal Automated Eligibility Verification System (AEVS) messages provide letter codes that indicate the scope of benefits for beneficiaries who have other coverage. The letter code "D" in the AEVS message means that the beneficiary has other dental coverage and the other carrier must be billed first. If the AEVS message indicates the beneficiary has other dental coverage but the beneficiary states he or she does not, the dental office should refer the beneficiary to his or her local county caseworker to correct the error.

How to Complete a Claim or TAR for a Beneficiary with Other Coverage

The fact that a beneficiary has other coverage does not change the prior authorization re-

quirements under Denti-Cal. The dental office should submit for prior authorization indicating the name of the primary carrier. Denti-Cal will process the prior authorization, and a Notice of Authorization will indicate the amount Denti-Cal would pay as if there were no other coverage.

When completing the TAR, be sure to include the following:

Field 13. OTHER DENTAL COVERAGE?

Check yes, indicating beneficiary has other dental insurance coverage.

Field 34. COMMENTS:

Provide full name and address of other coverage carrier and name, Social Security number, and group number of the policyholder.

When completing the claim for payment or NOA, be sure to include the following:

Field 10. ATTACHMENTS:

Include a copy of other coverage carrier's Explanation of Benefits/Readmittance Advice (EOB/RA) or Proof of Dental letter and fee schedule.

Field 13. OTHER DENTAL COVERAGE?

Check "yes," indicating beneficiary has other dental insurance coverage.

Field 34. COMMENTS:

Provide full name and address of other coverage carrier and name, Social Security number, and group number of the policyholder.

Field 37. OTHER COVERAGE AMOUNT:

Fill in amount to be paid by other coverage carrier.

Copayment Requirements for Medi-Cal Dental Services

Current California state law requires many Medi-Cal beneficiaries to pay a nominal fee, or "copayment," for dental services. Welfare and Institutions Code, Section 14134, requires copayment under the following circumstances:

- Nonemergency services in an emergency room
- A copayment of $5.00 is required for nonemergency services provided in an emergency room. A non-emergency service is defined as "any service not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death." (For exceptions, please refer to the section below.)
- Outpatient services
- A copayment of $1.00 for each visit for services is required for outpatient services provided by the following: physician, hospital, clinic, surgical center, or dentist. (For exceptions, please refer to the section below.)
- Drug prescriptions
- A copayment of $1.00 is required for each drug prescription or refill.

In addition to the exceptions listed below, any person 65 years of age or over is exempt from copayment for drug prescriptions or refills.

Exceptions to Copayment Requirements

Some Medi-Cal patients are exempt from copayment requirements. Copayment is never required from:

- Any person 18 years of age and under;
- Any woman who is receiving perinatal care (services during pregnancy and one month following delivery);
- Any person who is an inpatient in a health facility (hospital, skilled nursing facility or intermediate care facility);
- Any child in AFDC-foster care;
- Any person receiving dental services for which the program's total payment for the visit is $10.00 or less.

Collection of Copayment

It is the provider's responsibility to determine if a copayment is required according to the above criteria. The copayment, if applicable, should be collected by the provider at the time the dental services are performed. Even though the copayment may be required, the provider has the option of collecting or not collecting the copayment amount.

Copayment amounts are in addition to the usual Denti-Cal provider reimbursement. No deduction will be made from the amounts otherwise approved by Denti-Cal for payment to the provider.

A provider is prohibited by law from denying dental services if a beneficiary cannot make the copayment. The beneficiary is, however, liable to the provider for any copayment amount owed.

If you have any questions regarding these copayment provisions as they apply to dental services, please contact Denti-Cal toll-free at (800) 423-0507.

MEDI-CAL COPAYMENT CRITERIA		
SERVICES SUBJECT TO COPAYMENT	**COPAYMENT FEE**	**EXCEPTIONS TO FEE**
NON EMERGENCY SERVICES PROVIDED IN AN EMERGENCY ROOM: A nonemergency service is defined as "any service not required for alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death." Such services provided in an emergency room are subject to copayment.	$5.00	1. Persons aged 18 or under. 2. Any woman receiving perinatal care (services pregnancy and one month following delivery). 3. Persons who are inpatients in a health facility (hospital, skilled nursing facility or intermediate care facility). 4. Any child in AFDC-foster care. 5. Any service for which the program's payment is $10 or less.
OUTPATIENT SERVICES: Physician, optometric, chiropractic, psychology, speech therapy, audiology, acupuncture, occupational therapy, pediatric, surgical center, hospital or clinic outpatient, physical therapy and dental.	$1.00	
DRUG PRESCRIPTIONS: Each drug prescription or refill.	$1.00	All listed above, plus persons aged 65 or older.

Telephone Tips to Follow When Calling Denti-Cal

General Telephone Information

For information or inquiries, providers may call Denti-Cal toll-free at (800) 423-0507. When calling for information or inquiries, it is important that the dental office be prepared with the proper information, where applicable:

1. Patient Name
2. Patient Medi-Cal Identification Number
3. Billing Provider Name
4. Denti-Cal Provider Number
5. Type of Treatment
6. Amount of Claim or TAR
7. Date Billed
8. Document Control Number
9. Check Number

The Telephone Service Center Representatives are available for phone calls between 8:00 a.m. and 5:00 p.m., Monday through Friday; however, providers are advised to call between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m., when calls are at their lowest level. Patient history, claim/TAR status, or financial information can be accessed between 2:00 a.m. and 12:00 midnight, seven days per week, using the automated system. The automated system is also available for program information 24 hours a day, seven days a week. Provider Toll-Free Menu Options, and instructions for using the automated Interactive Voice Response System, are detailed on the following two pages.

In order for Denti-Cal to give you the best possible service and assistance, we ask that the toll-free number be utilized only within your office and that it not be distributed to your patients. Patients should be advised to use the Denti-Cal Beneficiary Services toll-free number: (800) 322-6384

Beneficiary Toll-Free Telephone Number

Since July 1, 1990, the Department of Health Services has provided a telephone inquiry service for Medi-Cal beneficiaries.

If your office receives inquiries from Medi-Cal beneficiaries, please refer them to the Beneficiary Services toll-free number: (800) 322-6384

The Beneficiary Services toll-free lines are available from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Either beneficiaries or their authorized representatives may use this toll-free number. Beneficiary representatives must have the beneficiary's name and Social Security number in order to receive information from the California Medi-Cal Dental Program.

The following services are available from the California Medi-Cal Dental Program by Beneficiary Services toll-free telephone operators:

1. A referral service to dentists who accept new Medi-Cal dental beneficiaries.
2. Assistance with scheduling and rescheduling Clinical Screening appointments.
3. Information about share of cost and copayment requirements of the California Medi-Cal Dental Program.
4. General inquiries.
5. Complaints and grievances.
6. Information about denied, modified or deferred Treatment Authorization Requests (TARs).

Medi-Cal Dental Program providers should use the provider-dedicated toll-free number to contact Provider Services: (800) 423-0507

Please do not give the provider toll-free number to your patients.

Interactive Voice Response System

The Denti-Cal Interactive Voice Response (IVR) System is a touch-tone only system providing general program information through the automated portion of the IVR 24 hours/day, seven days/week. If you know which key to press it is not necessary to listen to the entire message. Although enrollment status is accessible only by speaking with a Customer Service Representative Monday through Friday, between 8:00 a.m. and 5:00 p.m. (the best time is between 8:00 a.m. and 9:30 a.m., and 12:00 noon and 1:00 p.m.), patient history, claim/TAR status and financial information can be accessed using the automated system, seven days a week, 2:00 a.m. to 12:00 midnight, with little or no wait time.

The IVR system for the beneficiary toll-free line is also a touch-tone only system. Beneficiaries may continue to call (800) 322-6384 to access information by touch-tone or to speak with a customer service representative Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Standard Time (PST).

To access the IVR, enter the star key (*) followed by your Denti-Cal provider number. For provider numbers beginning with the letter B, press the star key (*), then the number 2 twice, followed by the remaining five numbers of your assigned provider number. For example, B12345 would be entered as * 2-2-12345, followed with the two digit service office number, e.g. 01.

The system will need to recognize which alpha character you are trying to enter into the keypad. By pressing the number 2 key, you have told the system that your provider number begins with either A, B, or C. By pressing the number 2 key again, the system now recognizes that entry as a B, for the second letter on that key. These are also the same steps used when accessing the Automated Eligibility Verification System (AEVS).

For provider numbers beginning with the letter G, press the star key (*), followed by the number 4 and then 1, and enter the remaining five numbers of your assigned provider number. For example, G12345 would be entered as * 4-1-12345, followed with the two digit service office number, e.g. 01.

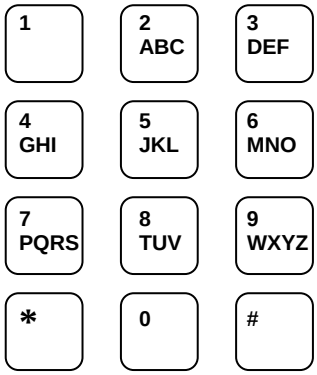
By pressing the number 4 key, you have told the system that your provider number begins with G, H, or I. By pressing the number 1, the system now recognizes that entry as a G, indicating the first letter on that key.

To assist you in entering alpha characters, each letter and its corresponding two-digit numeric code, always preceded by pressing the star key, is listed below.

Alphabetic Code Listing

A	*-2-1	N	*-6-2
B	*-2-2	O	*-6-3
C	*-2-3	P	*-7-1
D	*-3-1	R	*-7-2
E	*-3-2	S	*-7-3
F	*-3-3	T	*-8-1
G	*-4-1	U	*-8-2
H	*-4-2	V	*-8-3
I	*-4-3	W	*-9-1
J	*-5-1	X	*-9-2
K	*-5-2	Y	*-9-3
L	*-5-3	Q	*-1-1
M	*-6-1	Z	*-1-2

*Remember to press * before entering the two-digit code.*



NOTE: To check beneficiary eligibility, continue to use the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387.

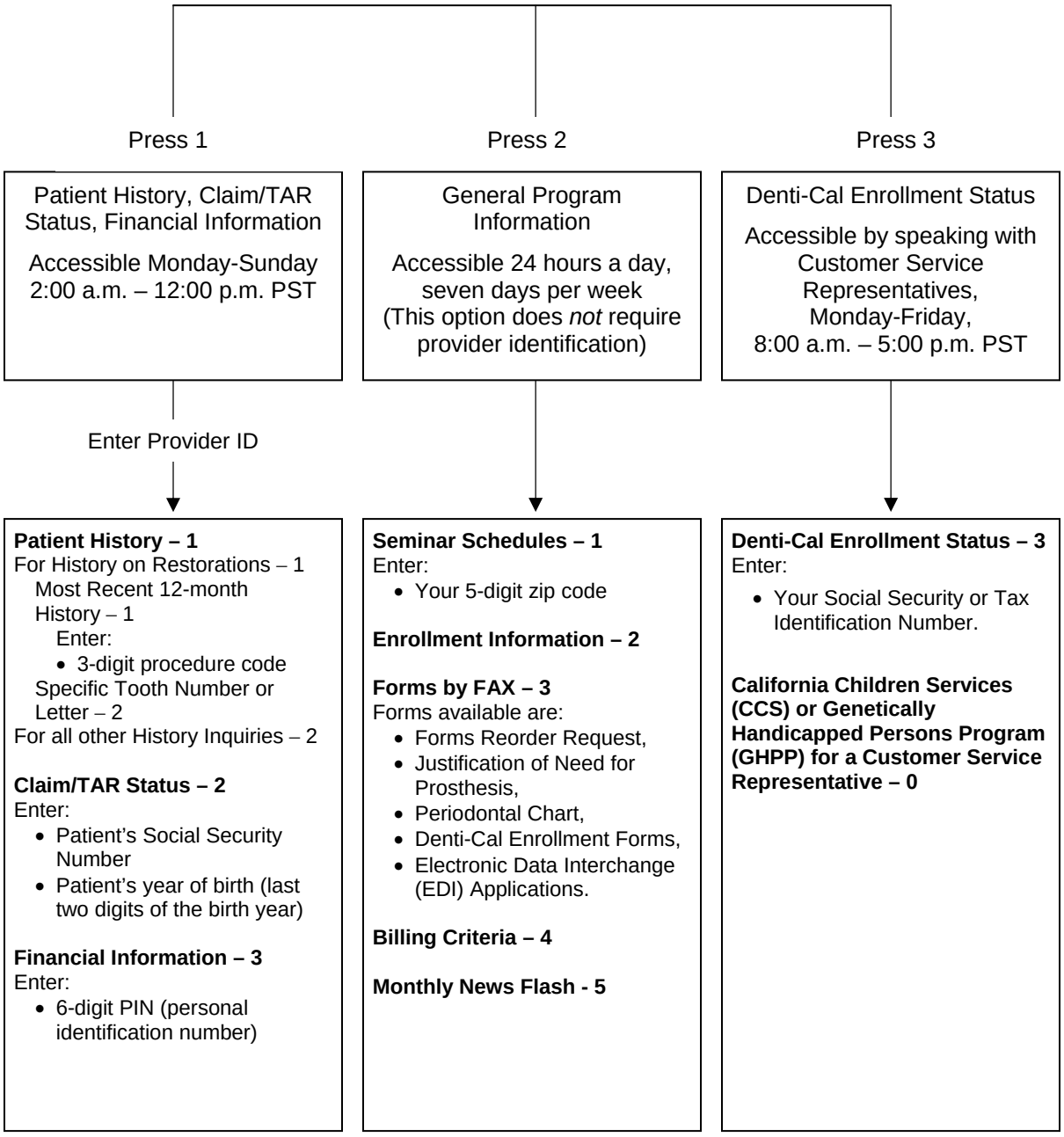
The IVR also allows providers to check history and billing criteria for radiographs and photographs (110-125) and the following restoration procedures, (600, 601, 502, 603, 611, 612, 613, 614, 645, 646, 670). To access this information, please call Denti-Cal toll-free at (800) 423-0507 between the hours of 2:00 a.m. and 12:00 midnight, Monday through Sunday. Patient history information can be obtained by pressing “1” from the main menu

and entering the provider identification (ID) number. If the provider ID number starts with "B," press the star (*) key, then the number "2," and the number "2" again, followed by the five numbers of your assigned provider number. If the provider number starts with "G" press the star (*) key, then the number "4," followed by the number "1," followed by the five numbers of your assigned provider number.

Begin entering patient information by pressing "1" again, then follow the prompts. This option in the IVR gives history on X-rays, prophylaxes, dentures, and many other procedures.

Provider Toll-Free Menu Options

(800) 423-0507



Written Correspondence

Most provider inquiries can be answered by using the automated system or operator-assisted options that are available through the toll-free telephone line. For your protection and confidentiality, Denti-Cal requires that certain inquiries and requests be made through written correspondence only. The types of inquiries and requests that should be sent to Denti-Cal in writing include:

- a change or correction in your provider name/address or other information concerning your dental practice;
- a request for a detailed printout of your financial information, such as your year-to-date earnings;
- a change in your direct deposit information, such as a different banking institution or new account number;
- a request to stop payment of or reissue a lost or stolen Denti-Cal payment check.

All written inquiries and requests should contain at a minimum the following information:

provider name

Denti-Cal billing provider number

date of request/inquiry

signature of billing provider

Your written correspondence should also include any other specific information that pertains to your inquiry or request.

Direct all written correspondence to:

Denti-Cal
California Medi-Cal Dental Program
Provider Services
P.O. Box 15609
Sacramento, CA 95852-0609

Upon receipt of your written correspondence, you will receive acknowledgement that your request has been received by Denti-Cal and is being processed.

Training Program

Denti-Cal offers an extensive training program that has been designed to meet the needs of both new and experienced providers and their staffs.

Seminars

Denti-Cal conducts basic and advanced seminars statewide. Seminar attendees receive the most current information on all aspects of the California Medi-Cal Dental Program. Basic seminars address general program purpose, goals, policies and procedures; provide instructions for the correct use of standard billing forms; and explain the reference materials and support services available to Denti-Cal providers. The expanded format of the advanced seminars offer in-depth information on topics such as Medi-Cal Identification Cards; dental criteria; x-ray and documentation requirements; processing codes; and other topics of specific concern to Denti-Cal providers.

In addition to the regular basic and advanced seminars scheduled each quarter, Denti-Cal conducts basic workshops and orthodontic specialty seminars throughout the year. The uniquely designed workshops give inexperienced billing staff a "hands-on" opportunity to learn about the Denti-Cal program and practice their newly acquired skills. Specialized training seminars have been developed for orthodontists who participate in the Denti-Cal Orthodontic Services for Handicapping Malocclusion Program; these intensified sessions cover all aspects of the Denti-Cal orthodontic program, including enrollment and certification, completion of billing forms, billing procedures and criteria and policies specific to the provision of Denti-Cal orthodontic services.

Each Denti-Cal training seminar is conducted by an experienced, qualified instructor.

Continuing education credits for all seminars are offered to dentists and registered or certified dental assistants and hygienists. Denti-Cal training seminars are offered free of charge at convenient times and locations. Although there are no prerequisites for attendance at any type of seminar, in order for Denti-Cal to continue offering free provider training seminars and workshops, making reservations well in advanced is recommended. If unable to keep the reservation, please notify Denti-Cal promptly. Space is limited and “no-shows” prevent others from being able to attend.

Training Videotapes

Education and training services provided by Denti-Cal include basic and advanced training videotapes.

The basic training videotape presents the following subjects:

- Billing procedures and forms completion: claims, TARs, NOAs, RTDs, Share of cost;
- Provider appeals process;
- Medicare/Medi-Cal crossover claims procedures;
- Beneficiary toll-free lines;
- Claim inquiry process.

The advanced training videotape presents more in-depth discussion of such topics as:

- Criteria requirements for Endodontics, Periodontics, crowns and oral surgery procedures;
- Hospital dentistry and Removable Prosthetics;
- Beneficiary eligibility;
- The Medi-Cal Identification Card;
- Use of provider toll-free telephone numbers.

The training videotapes are available on VHS tape and may be borrowed or purchased from Denti-Cal at a nominal cost.

To obtain a copy of the videotape(s), please contact Denti-Cal toll-free at (800) 423-0507.

On-Site Visits

Providers needing assistance with Denti-Cal claims processing may request an on-site visit by an a Provider Relations Representative.

This personal attention is offered to help you and your office staff better understand Denti-Cal policies and procedures so you can more easily meet program requirements. For the on-site visit, the Provider Relations Representative will have prepared an evaluation of your billing problems. Included in the evaluation are examples of claims, TARs, NOAs, RTDs, CIFs, and other appropriate documents which will be used to address specific problems. The representative may use a portable computer to access the Denti-Cal database to inquire about data specific to your office. This inquiry capability is particularly helpful in answering questions about the status of claims you have submitted and in clarifying misunderstandings of exactly how the claims processing system works.

Provider Appeals Process

There are three separate, specific procedures for asking Denti-Cal to reevaluate/appeal the denial or modification of a claim payment or a TAR.

To find out why payment of a claim was disallowed or to furnish additional information to Denti-Cal for reconsideration of a payment denial or modification, the provider should begin by submitting the Claim Inquiry Form (CIF) within six calendar months of the Explanation of Benefits date. Please refer to Section 3 of this manual for guidelines for submitting a CIF. Check the box on the CIF marked "CLAIM RE-EVALUATION ONLY." Remember to send a separate CIF for each inquiry.

Use the Notice of Authorization (NOA) to request re-evaluation of modified or disallowed procedures on your TAR. Check the "Re-evaluation is Requested" box in the upper right corner of the NOA. Do not sign the NOA when requesting re-evaluation. Include any additional documentation for reconsideration and return the NOA to Denti-Cal. Re-evaluations may be requested only once. Section 3 of this manual lists the complete procedures for requesting re-evaluation of a TAR using the NOA.

If upon reconsideration Denti-Cal upholds the original decision to disallow payment of the claim or authorization of treatment, the provider may request an appeal. In accordance with Title 22 of the California Code of Regulations (CCR), Denti-Cal has established an appeals procedure to be used by providers with complaints or grievances concerning the processing of Denti-Cal TARs or claims for payment. The following procedures should be used by dentists to appeal the denial or modification of a TAR or claim for payment of services provided under the California Medi-Cal Dental Program:

Provider First-Level Appeals

a. The provider must submit the appeal by letter to Denti-Cal within 90 days of the action precipitating the complaint or grievance. Claim Inquiry Forms should not be used for this purpose.

b. The letter must specifically request a first-level appeal in order to ensure proper handling.

c. The appeal should clearly identify the claim or TAR involved and describe the disputed action.

d. First-level appeals should be directed to:

Denti-Cal
California Medi-Cal Dental Program
Provider Services
Appeals Unit
P.O. Box 13898
Sacramento, CA 95853-4898

Denti-Cal will acknowledge the written complaint or grievance within 21 calendar days of receipt. The complaint or grievance will be reviewed by Denti-Cal Provider Services, and a report of the findings and reasons for the conclusions will be sent to the provider within 30 days of the receipt of the complaint or grievance. If review by Provider Services determines it necessary, the case may be referred to Denti-Cal Professional Review.

If the complaint or grievance is referred to Denti-Cal Professional Review, the provider will be notified that the referral has been made and a final determination may require up to 60 days from the original acknowledgement of the receipt of the complaint or grievance. Professional Review will make its evaluation and send findings and recommendations to the provider within 30 days of the date the case was referred to Professional Review.

The provider should keep copies of all documents related to the first-level appeal.

Under Title 22 regulations, a Denti-Cal provider who is dissatisfied with the first-level appeal decision may then use the judicial process to resolve the complaint. In compliance with Section 14104.5 of the Welfare and Institutions Code, the provider must "seek judicial remedy" no later than one year after receiving notice of the decision.

Beneficiary Complaint or Grievance Procedures

A Medi-Cal beneficiary with a complaint or grievance concerning scope of benefits, quality of care, modification or denial of a claim or Treatment Authorization Request, or other aspect of services provided under the California Medi-Cal Dental Program must direct the complaint or grievance as follows:

Initial Appeal to Provider

Any agency, department or individual accepting the initial information regarding a complaint or grievance should advise the beneficiary to direct the complaint or grievance to the provider responsible for the dental needs of the beneficiary. The beneficiary should initiate action by submitting the complaint or grievance to the provider, identifying the complaint or grievance by specifically describing the disputed service, action, or inaction. The provider responsible for the dental needs of the beneficiary should attempt to resolve the complaint or grievance within the parameters of the California Medi-Cal Dental Program.

Notification to Denti-Cal

When action at the provider level fails to resolve the complaint or grievance, the beneficiary should telephone Denti-Cal at (800) 322-6384, identify himself/herself and the provider involved, and specifically describe the disputed services, action, or inaction. The beneficiary may also complete the Beneficiary Medi-Cal Dental Program Complaint Form (a sample, found on the following pages, is to be copied for the beneficiary) and return it to Denti-Cal at the address indicated on the form.

Telephone Complaint or Grievance

Denti-Cal Beneficiary Services will make every effort to resolve the problem at this level. Denti-Cal may refer the beneficiary back to the provider for appropriate suggestions for resolution of the problem, or send the Beneficiary Medi-Cal Dental Program Complaint Form to the beneficiary for completion.

Written Complaint or Grievance

Denti-Cal will acknowledge the written complaint or grievance within five (5) calendar days of receipt. The written complaint or grievance may be referred to a Denti-Cal dental consultant, who will determine the next course of action, which could include contacting the patient and/or provider, referring the patient to a clinical screening examination by a Denti-Cal regional dental consultant, or referral to the appropriate peer review body.

When a copy of the beneficiary's chart and other pertinent information is requested from your office, it is important that this information be submitted to Denti-Cal within the timeframe indicated on the request to avoid potential recoupment of funds previously paid for the service(s) at issue.

Denti-Cal Professional Review

Denti-Cal will review the beneficiary's complaint or grievance and send a letter summarizing its conclusion and reasons substantiating the decision to him or her within 30 days of the receipt of the complaint or grievance. If it is determined that there is a need to recoup funds for previously paid service(s), Denti-Cal will issue the provider a written notification
indicating the specific reasons for the recoupment.

If a beneficiary is not satisfied with the decision of the complaint review process, he/she may ask for a Fair Hearing by contacting:

Office of the Chief Administrative Law Judge
State Department of Social Services
P.O. Box 13189
Sacramento, CA 95813-3189
(800) 952-5253

Denti-Cal
California Medi-Cal Dental Program

BENEFICIARY MEDI-CAL DENTAL PROGRAM COMPLAINT FORM

Please fill in the form below and describe your questions or complaints completely. This information is important and necessary to research and resolve your questions or complaints.

MEDI-CAL IDENTIFICATION NUMBER: _____

SOCIAL SECURITY NUMBER: _____

TELEPHONE NUMBER: (_____) _____- _____

MESSAGE TELEPHONE NUMBER: (_____)_____

YOUR REPRESENTATIVE (if not yourself):

NAME:_____

ADDRESS: _____

CITY: _____, STATE: _____ ZIP CODE _____

TELEPHONE NUMBER: (_____)_____

YOUR DENTAL PROVIDER"S NAME:_____

ADDRESS:_____

CITY: _____, STATE: _____ ZIP CODE _____

TELEPHONE NUMBER: (_____)_____

Denti-Cal
California Medi-Cal Dental Program

BENEFICIARY MEDI-CAL DENTAL PROGRAM COMPLAINT FORM (Page 2)

TYPE OF COMPLAINT:

_____Dentist service was incomplete or unsatisfactory

_____Regional Screening process was unsatisfactory

_____Other

_____Comments (Please describe your questions or complaints/ grievances completely here. Use the reverse side of this form or additional pages if you need additional space.)

_____

_____

_____

_____

_____

PLEASE SIGN AND DATE THIS FORM:

It may be necessary to obtain your medical records from your dental care provider. Your signature below authorizes release of your dental records to Denti-Cal.

SIGNATURE_____DATE_____

Return this form to: Medi-Cal Dental Program
Beneficiary Services Group
P. O. Box 15539
Sacramento, CA 95852-1539

When we receive this information, we will research your questions or complaints/grievances and notify you of our findings. If it is necessary for you to appear for a clinical examination in order to resolve this matter, we will notify you in writing of the date, time, and location of this appointment.

Denti-Cal
California Medi-Cal Dental Program

Denti-Cal

California Medi-Cal Dental Program

Notice from the Department of Managed Health Care

You may file a complaint with the California Department of Managed Health Care after you have completed Delta's grievance process or after you have been involved in Denti-Cal's grievance process for 30 days. You may file a grievance with the Department immediately in an emergency situation that is one involving severe pain and imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at **(1-800-322-6384)** and use your plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

Fair Hearing

Fair Hearing

According to Title 22, Section 50951:

> *Applicants or beneficiaries shall have the right to a state hearing if dissatisfied with any action or inaction of the county department, the department of health services or any person or organization acting in behalf of the county or the department relating to medical eligibility or benefits.…*

Authorization of Services Through the Fair Hearing Process

Services can be authorized through the Fair Hearing process in two ways:

1. a conditional withdrawal; or
2. a granted decision.

Conditional Withdrawal

A conditional withdrawal can be offered to the beneficiary upon receipt of additional information from either the beneficiary or the dentist. If the beneficiary agrees to the conditions of the withdrawal, a pink authorization letter is mailed to him/her. The beneficiary may then take the authorization to the Denti-Cal provider of his/her choice. The treating provider must meet the following requirements in order to be paid for services provided:

1. Be an enrolled Denti-Cal provider
2. Verify the patient's eligibility
3. Provide ONLY the service(s) authorized within the 180 days of the date on the letter
4. Submit a claim for payment within the authorization period. The claim must include the original pink authorization letter bearing the original signature. Mail the claim for payment to:

   Denti-Cal Program
   ATTENTION: FAIR HEARINGS
   P. O. Box 13898
   Sacramento, CA 95853

Granted Decision

If an administrative law judge determines a denied service should be authorized, the judge will issue a GRANTED DECISION. Through the action, the beneficiary is authorized to take the decision to the Denti-Cal provider of his/her choice to receive services.

1. Be an enrolled Denti-Cal provider
2. Verify the patient's eligibility
3. Provide ONLY the service(s) authorized in the "ORDER" section of the decision within 180 calendar days of the signed order
4. Submit a claim for payment within 60 calendar days from the date of the last completed service performed within the authorization period. The claim must include the Granted Decision and should be mailed to the following address:

   Denti-Cal Program
   ATTENTION: FAIR HEARINGS
   P. O. Box 13898
   Sacramento, CA 95853